University of Alberta

Fiduciary Obligations of Physicians in Clinical Trials

by

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ABSTRACT

It is well established in law that physicians owe a fiduciary obligation to their patients in the context of a traditional doctor-patient relationship, which means that they must act in the best interests of their patients in all matters concerning their care. However, courts impose fiduciary obligations only after a careful consideration of each relationship's specific circumstances. The question this paper examines is whether or not physicians owe a fiduciary obligation to patients when they encounter them as research subjects in clinical trials. The answer to this question is particularly important since the concept and design of randomized controlled trials in biomedical research, as well as certain commonly accepted practices seriously challenge the ability of physician-researchers to act in the best interests of patient-subjects. This paper also considers the implications of finding physician-researchers to be fiduciaries on the scope of their obligation to patients and other research subjects and on the permissibility of certain clinical trial practices.

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INTRODUCTION

It is well established in Canadian jurisprudence that physicians owe a fiduciary obligation to their patients in the course of delivering professional services[1]. As a result, doctors are held to the highest legal standard of conduct and required to act with the "utmost good faith and loyalty" in dealing with patients.[2]

However, in the last couple of decades, physicians, as part of their practice, have become increasingly involved in conducting clinical research where they encounter patients in the role of research subjects. Most of this research takes the form of randomized controlled trials, designed to help pharmaceutical companies test new treatments[3] for their safety and efficacy in order to obtain regulatory approval for manufacturing and market distribution.[4]

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[1] See *McInerney v. McDonald*, [1992] 2 S.C.R. 138 [hereinafter *McInerney*]; *Norberg v. Wynrib*, [1992] 2 S.C.R. 227 [hereinafter *Norberg*], *Hodgkinson v. Simms* [1994] 3S.C.R.377 [hereinafter *Hodgkinson*] are the recent Supreme Court decisions that re-emphasized the fiduciary nature of the physician-patient relationship.

[2] This fact holds less strongly in Australia where doctors have some but not all fiduciary duties, see *Breen v. Williams*, (1996) 186 C.L.R. 71 (H.C. Aust); and even less so in Great Britain where courts have been reluctant to characterized a doctor-patient relationship as fiduciary. See *Sidaway v. Bethlem Royal Hospital Governors* [1985] A.C. 871 (H.L.).

[3] By "treatment" in this case one should understand substance, procedure, or device. For the purposes of this paper, we will be talking about clinical trials that test drugs.

[4] In order for a clinical trial to proceed in Canada, it has to be approved by Health Canada and by a local Research Ethics Board ("REB"). Health Canada assesses clinical trials before they are conducted (see *Food and Drug Act*, SRC c.F-27 and *Food and Drug Regulations*, CRC, c.870, Part C, Division 5), as well as their results determining the appropriateness of a drug for the Canadian market (See Food and Drug Regulations, *supra*, Part C, Division 8.) In addition, ethical soundness and appropriateness of proposed clinical trials as it is described in a research protocol and other relevant documentation are evaluated by local research ethics boards, see *Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans*, Public Works and Government Services Canada, 1998, online: <http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm> Section 1, A, Article 1-1 [hereinafter *TCPS*].

As the number of clinical trials steadily increases, so too do concerns for the safety of research subjects, and the ethical and legal permissibility of certain practices in them. While some patients no doubt derive significant therapeutic benefits from participating in clinical trials, the general concern about using patients in risky experimental procedures which may hold little or no therapeutic benefit for them remains. The treatment of these patients in clinical trials is often compromised for the sake of obtaining new scientific knowledge, or simply for a pharmaceutical company to get its product on the market.

Physicians-researchers, who would naturally be expected to safeguard the interests of patient-subjects in clinical trials, are often not in a position to do so. Having simultaneously undertaken responsibilities for research and patient care in clinical trials, they often face an uneasy choice: whose interests, as between their patients and the clinical trial, should they put first? This creates a problem of divided loyalties for them that often leads to serious conflicts of interest. In addition, since about 80% of clinical trials in Canada are funded by commercial sponsors,[5] this dilemma becomes further intensified by the presence of considerable financial incentives offered by commercial sponsors which can influence physicians' professional judgment and discretion, steering them away from their prime responsibility to act in the best interests of their patients.

As a result, the pressure of conflicting responsibilities and conflicts of interest seriously challenge trust and confidence underlying the traditional doctor-patient relationship in clinical trials, undermining thereby physician-researchers' ability to adequately protect the interests of patient-subjects in them. Fiduciary law, which has traditionally been applied to regulate physician-patient relationships, on the contrary, demands that physicians serve the best interests of their patients with undivided loyalty, discouraging even the appearance of conflict in their conduct.

This paper, therefore, considers the following question: given the nature and purpose of clinical trials, what role does fiduciary law play in regulating relationships of physicians and patients in them, and what are the practical implications of this for physicians' obligations to patient-subjects? Part I of this paper begins to answer these questions by describing the concept and design of randomized controlled trials, the issues they raise, as well as their regulation by so called "soft law". Part II then examines the principal tenets of fiduciary law, and the way Canadian courts have applied them to the doctor-patient relationship, and considers whether existing case-law provides a sufficient basis for holding physicians to the standards of fiduciary law in clinical trials. Part III examines the physician-patient relationship in the context of clinical trials in order to determine whether and how fiduciary law principles should apply to this relationship and considers some possible implications of physician-researchers' being found fiduciary. What will become apparent from this analysis is that some elements of the clinical trial design, as well as some of their commonly

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[5] See "Building on Values: The Future of Health Care in Canada" (2002) *Report of the Commission on the Future of Health Care in Canada*, at 83 online: <http://dsp-psd.communication.gc.ca/Collection/CP32-85-2002E.pdf>.

accepted practices do not sit well and often openly conflict with essential principles of fiduciary law.

The full scope of physician-researchers' fiduciary obligation and the related issue of the appropriate regulation of clinical trials are subjects that require further careful consideration by academics, the medical profession and other interested parties. The purpose of this paper, in the mean time, is to identify and describe the issues related to the fiduciary obligation of physicians in clinical trials.

I. RANDOMIZED CONTROLLED TRIALS: CONCEPT, DESIGN, GUIDELINES

> Experimentation in man for scientific purposes is as old as recorded history. There is little new in terms of principle. What is new is the rapid increase in the magnitude of the problems. There is a great need in reexamination of the ethical aspects of the procedures involved. This need is imposed by progress in science and by the advance in moral and ethical standards.
>
> *H. K. Beecher*[6]

The main purpose of this part is to describe the concept, design and conduct of clinical trials, as well as physicians' interaction with patients and other research subjects in them. Discussion of the ethical permissibility of randomized controlled trials will provide a context for examining later in the paper the legal and ethical responsibilities of physician-researchers to patient-subjects in them.

A. Current Context in Which Randomized Controlled Trials are Conducted

Research or experimentation, in one form or the other, has always been a part of medical practice.[7] The concept of a clinical trial, especially in its scientifically preferred format – a randomized controlled trial - is a relatively new notion.[8] The significance of clinical trials for the modern practice of medicine cannot be overestimated. Hundreds and thousands of new medical treatments become available to patients every year thanks to the testing conducted in clinical trials. Besides, "clinical trials are considered an important part of innovative patient care for diseases where established treatments are not available or not adequate".[9] Often the only alternative for patients is to enter an experimental protocol. According to Beecher, "[t]he concept of the controlled clinical trial may have done more to make modern medicine a reality that any other single factor."[10] However, before describing what randomized controlled trials are and how they are conducted, a number of general observations about the modern practice of medicine and doctor-patient relationship are in order.

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[6] *Research and the Individual: Human Studies* (Boston: Little, Brown and Company, 1970) at 11 [hereinafter *Beecher, Research & Individual*].

[7] See *e.g.* G. H. Brieger "Human Experimentation: History" in W. T. Reich, ed., *Encyclopedia of Bioethics* (New York, Free Press, 1978), and R. Gordon, *The Alarming History of Medicine,* (Mandarin Paperback, 1993).

Medical practice has changed dramatically in the last several decades. This is largely due to unprecedented advancements in science and technology. Driven by these changes, the practice of medicine has become increasingly scientifically based, leading to a recognition that medical progress depends on research and experimentation.[11] Conducting research has become an integral part of medical practice[12] and, as a result, is more often viewed as an ethical obligation of physicians, who are now expected to advise and treat their patients on the basis of up-to-date and scientifically substantiated information, rather than on the basis of custom, anecdotal evidence or clinical rumor.[13] Hence, while acknowledging the indisputable benefits of science and technology for the practice of medicine, it is also important to recognize that technology has altered significantly the form and the meaning of the doctor-patient relationship. For example, in rendering a diagnosis and deciding upon treatment, more weight is given to objective information, obtained from scientific tests and medical equipment, than to evidence given by patients at the time of their personal encounter with doctors. As Reiser and Anbar note:

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[8] However, as early as in 1814, La Place suggested application of statistics with the use of two groups, one treated, the other used as a control. See *Beecher, supra,* note 1. Beecher also observed that "Since the early 1940s Bradford Hill has held that the general emphasis on careful planning in advance really constitutes a new development. Clinical trials as a planned and systematic research activity began to be conducted in mid-1970th.

[9] R. Worton & R. Saginur, "Worth the Risk", *Ottawa Citizen,* March 9, 2004, A15.

[10] *Beecher, supra,* note 6 at 9-10.

[11] See A. Klass, *There is Gold in Them Thar Pills* (Narmondsworth: Penguin Books, 1975), who states at 31 that it is clear that "...human medical experimentation must continue, or progress in drug treatment will cease".

> Increasingly, practitioners encounter patients for relatively brief and intermittent periods – such as the consultant visiting a hospitalized patient who he or she has never before met. In such visits the technical aspects often dominate, for there is no time or prior relationship to determine much about who the patient is, or what the patient thinks about the illness or the needs it engenders.[14]

Medical practice and the doctor-patient relationship are also significantly affected by social and economic factors. Health care has become "dangerously expensive",[15] and as a result, more commercialized. The fact that doctors increasingly depend on those who employ and pay for their services considerably weakens their loyalty for patients and strengthens it for other parties. Moreover, various private and public groups often expect doctors to work for parties other than patients. Health policy in general focuses now on the health of the population at large rather than individual patients.[16]

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[12] See *Beecher*, *supra*, note 1, where he observed at 15 that "[a]t present the doctor may feel that his career prospects are as much bound up in his ability as a 'scientist' as his skills as a healer".

[13] D.J. Roy, J.R. Williams & B.M. Dickens, *Bioethics in Canada* (Toronto: Prentice Hall Canada Inc., 1993) at 322 [hereinafter *Bioethics in Canada*].

[14] S. J. Reiser & M. Anbar, ed., *The Machine at the Bedside: Strategies for Using Technology in Patient Care* (New York: Cambridge University Press, 1984) at 26.

The expectations of modern western society, which is increasingly materialistic and consumer-oriented, have also risen significantly: it now expects the best existing, rather than the best available treatment for patients, regardless of cost.[17] The pharmaceutical industry responds to these expectations by testing thousands of new medical treatments for their market distribution each year. Each clinical trial is a major and complex undertaking that may require more than a decade to complete, cost millions of dollars,[18] involve thousands of research subjects and, for its implementation, depends on the contribution and collaboration of many players, including research institutions, commercial and government sponsors, regulators, researchers and research volunteers.[19] The magnitude of the undertaking leading to production of new drugs is so great as to cause some to refer to it as a "research enterprise"[20] or "an industrial-medical complex".[21]

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[15] M. Rodwin, *Medicine, Money, and Morals: Physicians' Conflict of Interest* (New York: Oxford University Press, 1993) "Foreword" [hereinafter *Rodwin, Medicine, Money and Morals*].

[16] See M. A. Rodwin, "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System" (1995) 21 Am. J. L. & Med. 241 at 253 [hereinafter *Rodwin, Strains*].

[17] See e.g., J.C. Irvine, "The Physician's Duty in the Age of Cost-containment", in *Current Issues in Health Law*, The 1994 Isaac Pitblado Lectures, Sponsored by The Law Society of Manitoba, The Manitoba Bar Association and the University of Manitoba, Faculty of Law, 128; T. Caulfield & G. Roberson, "Cost-containment Mechanisms in Health Care: A Review of Private Law Issues" (2000) 27 Man. L. J. 1 [hereinafter *Caulfield & Roberson, Cost-containment*].

[18] The estimated cost of developing new medications in the United States ranges between $300 to $ 600 million. See e.g., T. Bodenheimer, "Uneasy Alliance – Clinical Investigators and the Pharmaceutical Industry" (2000) 342:20 N. Engl. J. Med.1539 at 1539 as cited by T. Lemmens & P.B. Miller, "The Human Subjects Trade: Ethical and Legal Issues Surrounding Recruitment Incentives" (2003) 31 J. L. Med. & Ethics 398, at 400 [hereinafter Lemmens & Miller].

In order to set up a clinical trial, sponsoring pharmaceutical companies approach physicians with offers to pay them for conducting clinical trials, obtaining in return physicians' expertise and access to the required patient population. Physician-researchers, patients-subjects, and pharmaceutical companies, share a common objective – a desire to contribute to the development of more effective treatments. However, they also have their own reasons for participating in clinical trials and their particular interest in them. Reconciling these interests is one of the main challenges associated with clinical trials and signals a need to critically and continually assess the ethical framework for biomedical research and delivery of patient care in it.

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[19] *ibid.Lemmens & Miller.*

[20] J.A. Zivin, "Understanding Clinical Trials" 4 Scientific American, 2000, 69.

[21] See M. Stauch & K. Wheat with J. Tingle, *Sourcebook on Medical Law* (Cavendish Publishing Ltd, 1998) [hereinafter *Sourcebook*] at 572; S. Lewis et al., "Dancing with the Porcupine: Rules for Governing the University-Industry relationship," (2001) 165:6 CMAJ 783 [hereinafter *Lewis*] where at 783 the author indicates that pharmaceutical industry in Canada annually spends CAN $900 million on in-house research and development, invests additional CAN $161 million in Canadian universities and teaching hospitals; federal and provincial funding agencies contribute approximately 4300 million.

B. Concept and Design of Randomized Controlled Trials

A randomized controlled trial (RCT) is a systematic research undertaking directed at testing the safety and efficacy of an experimental treatment on humans that requires: (1) two or more similar groups of subjects studied at the same time, but differing in their treatment; (2) random distribution of the subjects; and (3) withholding treatment from one group or the other.[22]

1. Phases of Randomized Controlled Trials

A completely new treatment must go through at least three phases of a clinical trial, before it can be approved for manufacturing and marketing.[23] Each phase has a specific purpose and design. An RCT is considered the gold standard for clinical drug research,[24] since its design is said to reduce bias and thereby increase the probability of reliable results.[25]

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[22] See also A. B. Hill, "Medical Ethics and Controlled Trials" (1963) 1 Brit. Med. J. 1043, as referred to in *Beecher, supra*, note 6 at 2-3.

[23] There is also Phase IV trials which are designed to assess the side effects and acceptance by patients of an already-marketed drug. It is also described as a form of post-marketing advertising and is often conducted by physicians in private practice who are paid per-capita fee by sponsors. The *TCPS* draws attention to the fact that during this phase of clinical trials, a physician's professional integrity may be compromised by financial incentives (finders' fees, billing practices, utilization of public resources), and other conflicts of interest, and therefore warrants careful examination by researchers and REBs. See *TCPS, ibid.* Art.7.2. Commentary.

[24] See *Sourcebook*, *supra*, note 21 at 524.

Phase I Clinical Trial: Screening for Safety

The first phase of a clinical trial involves a relatively small number of research subjects and is designed to allow researchers to gather information about whether a drug candidate is safe for humans, and if so, what dosage humans can tolerate. Therefore, this phase is sometimes called a "toxicity trial". Research subjects are normally healthy volunteers who in some cases receive consideration for participation from the sponsors of newly developed drugs. They do not expect to obtain the therapeutic benefit of the investigated drug, which explains why this type of study is also called a Phase I non-therapeutic clinical trial.

The fact that in Phase I clinical trials a drug is tested on humans for the first time and its effect on the human organism cannot be entirely predicted, carries great risk for the volunteers. Where there is a risk of extremely serious side-effects, only patients with the condition that the experimental treatment is intended to treat are invited to participate, since it is presumed that the potential benefit of the experimental treatment may be worth its risks for them.[26] Therefore, often very seriously or terminally ill patients, such as cancer or AIDS patients, as well as patients for whom all conventional therapies have failed,

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[25] D.L .Sackett, "Bias in Analytic Research." 32 Journal of Chronic Disease (1979) 51, at 61 as cited in *Bioethics in Canada*, *supra,* note 7 at 317.

[26] It is important to view this as a general presumption only, rather than as a default rule. See B. Freedman, "Compassionate Access to Experimental Drugs and Catastrophic Rights", text of the presentation to the House of Commons Subcommittee on HIV/AIDS, Ottawa 13 December 1995, 3:1Canadian HIV/AIDS Policy & Law Newsletter, 1996, at 1 [hereinafter *Freedman, Compassionate Access*], wherein the author stated,

> Patients who are desperately ill sometimes consent to research with the idea that they have nothing to lose. This is a mistake. No disease is so dreadful and

agree to participate in Phase I trials, hoping that the experimental treatment will provide them with some symptom relieve or possibly with a last chance cure.[27] The *TCPS* warns that, in such cases, perception of the risks and benefits of research by patients, their families and researchers may be distorted[28] and calls for special attention of REBs and physicians to them.

Phase II Clinical Trial: Establishing Protocol

The purpose of a Phase II clinical trial is to find optimal experimental conditions that will allow the third and final phase of the trial to give a definite answer. Phase II clinical trials involve patients who suffer from the disease to be treated by an investigated drug.

Phase II trials are commonly conducted in a randomized double-blind format. Research subjects are randomly divided into two groups, called arms of the trial, one of which receives the experimental drug, while the other, referred to as the control group, receives an approved treatment commonly used for a given condition, or a placebo. [29] A trial is said to be controlled when the results

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imminent that it cannot be made worse by the inapt application of an experimental treatment.

[27] In *TCPS* this category of participants is referred to as "desperate populations whose therapeutic options have been exhausted", see *TCPS, supra*, note 4 Art 7.2.It also notes that, even though such studies may be designated as Phase I non-therapeutic clinical trials, they in fact should properly be designated as mixed I/II or pure Phase II clinical trials, presumably because of the expected therapeutic effect, *supra*.

[28] This affects not only the ability of research subjects to give informed consent, but also the ability of researchers and REBs to understand when it is appropriate to stop the research procedure or withdraw a particular research subject from the experimental treatment in order to protect his safety.

[29] The rationale for using a control group of sufficient size and a randomized double-blind format is explained in S. Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992) at 159 as follows:

of one treatment are being monitored in relation to the results of another treatment, no treatment or a placebo. "Double-blind" means that at the time of randomization neither the subject nor the researcher knows which arm the subject is assigned to.[30]

Randomization and double-blinding are the two main techniques employed in controlled clinical trials to minimize bias and increase the probability of producing reliable comparative information about the relative safety and efficacy of new drugs, which is essential for the drug's approval. However, what is essential for science does not always makes sense to patients, and thus these and other practices of clinical trials raise many ethical concerns.

Phase III Clinical Trial: The Final Test

In the third phase of a clinical trial researchers hope to obtain an authoritative confirmation that a drug works. This phase is the one most familiar to the public since hundreds and thousands of patients participate in them.

> If researchers somehow knew a drug candidate truly was a better treatment, however, there would be no need for a trial. It is scientifically essential that the division of subjects into the test or control groups occur and that it be entirely random. Otherwise the final results will be skewed. If the test group were to consist mainly of patients for whom all other drugs failed (and thus were more likely to be among the most sickest patients), the drug candidate being screened could appear to be less effective than the placebo, even if it were not, simply because the patients receiving the drug started off in worse health. Conversely, if the leaders of the clinical trial consciously or unconsciously administered the test drug to healthier patients, it could appear more effective.

[30] The fact that the trial must be "blind" does not mean that the doctor should be prevented from knowing which treatment the patient is receiving, but simply that the doctor must not know the arm of the trial until the patient has been assigned to it. See R. Nowak, *"Problems in Clinical Trials Go Far Beyond Misconduct"* (1994) 264 Science 1539.

By this point, researchers have defined at least one group of patients who are expected to benefit from the investigated drug, the nature of the benefit and the way to administer the treatment. Accordingly, the purpose of a Phase III trial is "to introduce a lasting beneficial change in the patients participating in the study", and to prevent or reverse the progression of a disease.[31] This suggests that, even though it is still uncertain at this stage whether the drug will prove to be an effective and safe treatment, it is administered to patients as a therapy, and is no longer viewed only as an object of study.[32]

What follows is a description of the nature of RCTs, major concerns associated with their conduct, and the ethical grounds on which physicians proceed with them.

2. Distinction Between Clinical Practice and Clinical Research

In defining the nature of clinical research it is important to distinguish it from clinical practice. The *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*,[33] which was among the first US documents to emphasize the importance of this distinction, concluded that the difference between clinical research and clinical practice is based on the intentions with which the activities are undertaken. It defined "practice" as

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[31] *Bioethics in Canada*, *supra*, note 13 at 315.

[32] *Ibid*.

[33] *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research,* The National Commission for the Protection of Human Subjects of Biomedical and

"interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success", and the term "research" as an activity designed to test an hypothesis, permitting conclusions to be drawn, and thereby developing or contributing to generalizable[34] knowledge.[35]

In a clinical trial, where clinical research and clinical practice (or patient care) are closely interconnected, it is sometimes difficult to say where one ends and the other begins.[36] For example, it is not always possible to draw a clear line between the two because research is often designed to evaluate therapies, or because the treatment of patients in some clinical trials is delivered in the context of a research protocol. In addition, it has often been said that the nature of medical practice in general is inherently experimental, meaning that "[e]ach treatment is one more repetition of an experiment with a statistically known

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Behavioral Research (1979) online: <http://www.nihtraining.com/ohsrsite/guidelines/belmont.html> [hereinafter *Belmont Report*].

[34] "Generalizable knowledge consists of theories, principles or relationships, or the accumulation of information on which they are based, that can be corroborated by accepted scientific methods of observation and inference", *International Ethical Guidelines for Biomedical Research Involving Human Subjects,* CIOMS, Geneva, 2002 at 7 online: <http://www.cioms.ch/frame_guidelines_nov_2002.htm> [hereinafter *CIOMS Guidelines*].

[35] *Belmont Report, supra,* note 33. Other organizations and academic commentators based this distinction on the design of the activity or on the use of novel agents or techniques. See *e.g.,* R. Levin, "The Boundaries Between Biomedical or Behavioral Research and the Accepted and Routine Practice of Medicine" in *The National Commission for the Protection for Human Subjects of Biomedical and Behavioral Research and Food and Drug Administration Rules and Regulations.* Fed. Reg, Vol. 46, No17, 1981: 56: 102 (c), as cited in C. Weijer, "Demarcating Research and Treatment: A systematic Approach for the Analysis of the Ethics of Clinical Research (1992) 40 Clinical Research 653 [hereinafter *Demarcating Research and Treatment*].

[36] It has been observed that the distinction between practice and research is, in some sense, artificial, since research and practice are not separable, and physician's work and behavior almost always involve both research and practice, see especially S. Piantadosi, *Clinical Trials: A Methodologic Perspective* (Paperback, John Wiley & Sons, 1997) at 30-31 [hereinafter *Piantadosi*].

probability of success".[37] It may, therefore, be impossible or impractical to define the whole study as either research or practice. Instead, it may be more useful to ask which of the study's interventions are grounded in research and which in therapy.[38]

Despite the intricate connection between clinical research and clinical practice, the two remain distinct activities and the distinction has ethical significance and practical implications. The major implication lies in the fact that, in clinical practice, patients' interests take precedence over any of the needs and requirements of the research procedure,[39] whereas in research, the interests of individual patients inevitably compete with those of the research study.[40]

Understanding the distinction between clinical research and clinical practice is also essential for knowing what activities should undergo ethics review for the protection of human subjects in research.[41] Freedman and others suggest that "[f]or the purposes of ethical review by IRBs, the demarcation of research must be done by a process of exclusion begun by defining therapy". They define therapy as a practice managed within the doctor-patient relationship, where therapeutic intervention is the product of a "sole agreement" between a physician and a patient and, as such, protected within the right of privacy. An IRB has no authority, therefore, to interfere with the therapeutic elements of this relationship.[42]

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[37] I. Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health* (Harmondsworth, Penguin Books, 1977) at 255.

[38] *Demarcating Research and Treatment*, *supra,* note 35 at 653.

[39] The same would apply to the case of a non-standard treatment.

[40] For example, the application of the basic ethical principles of respect for persons, beneficence, and justice may mean different things when applied in these two contexts. See *e.g.*, *Freedman, Compassionate Access, supra*, note 26 at 2.

[41] See *Belmont Report, supra,* note 33 Section A.

From a patient's perspective, understanding the distinction between clinical research and clinical practice is essential since they cannot expect the standard of care in clinical research to be the same as in clinical practice, and vice versa.

In summary, the difference between clinical research and clinical practice needs to be recognized and clearly understood by physicians-researchers, REB members and other players involved in organizing and conducting clinical trials, and openly and clearly communicated to patients participating in them to help cure possible "therapeutic misconceptions"[43]. This may involve, among other things, educating individuals involved in clinical trials, as well as including appropriate statements to this effect in informed consent forms.

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[42] *Demarcating Research*, *supra*, note 35 at 654.

[43] See *World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*, (1964), as last amended in 2002 online: <http://www.wma.net/e/policy/b3.htm> Art. 31[hereinafter *Helsinki Declaration*] which states:

> The physician should fully inform the patient which aspects of the care are related to the research. The refusal of a patient to participate in a study must never interfere with the patient-physician relationship.

3. Inherent Conflict: Interests of Society vs. Interests of Individual Subjects

As already mentioned, a clinical trial is a unique setting in which research and patient care are undertaken in very close connection. However, given that the goals of clinical research and clinical practice do not coincide, it is arguable that when pursued together, as occurs in clinical trials – which tests an experimental treatment on current patients in order to produce new treatments that will principally benefit future patients -- they not only conflict, but seem to be mutually exclusive.[44] Thus, the principle concern with conducting RCTs on patients in the course of treating their illness is that the so called "tailored" treatment for immediate, optimal individual care is often sacrificed in them in favor of controlled treatment for optimal scientific results about the relative efficacy and safety of two treatments for a population of patients.[45]

It is further arguable that this conflict, which on a more general level can be described as a conflict between public and private interests, is inherent in the idea of a clinical trial.[46] For physician-researchers this conflict translates into a problem of divided loyalty, which may lead to a conflict of interest resulting in a breach of the fiduciary duty they owe their patients. The question to be addressed, therefore, is the following: what are the ethical grounds on which physicians can, despite the foregoing conflict, proceed with RCTs and enroll their patients in them?

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[44] See *Beecher, Research & Individual, supra,* note 6, wherein, at 182, he made the following observation in this regard:

> In therapy, the patient is an end; he may also secondarily be a means in that what is learned in his treatment may have general scientific value. In science, the patient or subject is a means, not an end, to general scientific advancement, when what is done is not for his direct welfare, but for that of science in general.

[45] See *Bioethics in Canada, supra,* note 13 at 318.

[46] This should not be understood, however, that RCTs are inherently unethical.

4. Ethical Grounds for RCTs

The *TCPS,* relying on the 1986 text of the *Declaration of Helsinki,*[47] issued by the World Medical Association, and academic literature in the area,[48] state that physicians can enroll patients in RCTs only when there is a clinical equipoise. The *TCPS* defines clinical equipoise as,

> a genuine uncertainty on the part of the expert medical community about the comparative therapeutic merits of each arm of a clinical trial. The tenet of clinical equipoise provides a clear moral foundation to the requirement that the health care of subjects not be disadvantaged by research participation.[49]

In other words, genuine uncertainty about the preferred treatment allows physicians to offer their patients participation in RCTs without abandoning their fiduciary duty to protect patients' well-being.[50] A trial is initiated to resolve this uncertainty and, as soon as the trial question is answered, the clinical trial loses its ethical justification and should be ended.[51]

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[47] *World Medical Association, Declaration of Helsinki* (1964, as revised 1986), para. II.3.

[48] See especially B. Freedman, "Equipoise and the Ethics of Clinical Research" (1987) 317:3 NEJM 141; see also *Demarcating Research and Treatment, supra,* note 35.

[49] *TCPS, supra,* note 14, Section 7, A, 7.1.

[50] See *Draft-Report of the National Placebo Working Committee,* November 2003, Section 4 B online: <http://www.cihr-irsc.gc.ca/e/services/19301.shtml> [hereinafter *Placebo Report*] at 28:

> Uncertainty as to equivalence or superiority of the study drug to established effective treatment assures that physicians do not abandon their fiduciary duty towards their patients when recommending a clinical trial to patients.

However, the practical application of the principle of clinical equipoise, as a guide for REBs in evaluating the ethical soundness of RCTs, is not straightforward. Clinical equipoise is a complex notion which continues to generate debate about its meaning, including what should be understood by the concept of "expert medical community", whether "genuine uncertainty" should exist in the medical community or in the mind of the individual clinical investigator,[52] and whether or not other factors, such as the values of the patients-subjects and their personal views as to what the "best treatment" for them is, should also be considered.[53] However, what is important to understand for the purposes of this paper is that the principle of clinical equipoise makes it unethical for physicians to enroll their patients in a RCT if patients will be offered treatment that is known to be inferior to that already available for their conditions. Such treatment also arguably falls below the required standard of care and could be considered negligent on the part of a physician-researcher.[54]

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[51] While logically correct, this requirement could be difficult to implement in practice, because many trials would have to be stopped before they generated statistically necessary data to substantiate their conclusions. *Ibid.*

[52] See response to C. Weijer *et. al.*, "For and Against: Clinical Equipoise and not the Uncertainty Principle is the Moral Underpinning of the Randomized Controlled Trial" (2000) 321 BMJ 756 online: <http://bmj..bmjjournals.com/cgi/eletters/321/7263/756>; B. Freedman, "Equipoise and the Ethics of Clinical Research" (1987) 317 N. Engl. J. Med. 141.

[53] See R.J. Lilford, "Ethics of Clinical Trials from a Bayesian and Decision Analytic Perspective: whose Equipoise it is Anyway?" (2003) 326 BMJ 980.

[54] See K. Glass & T. Leroux, *Legal Perspective in Placebo Report*, *supra*, note 50.

In addition to adhering to the principle of clinical equipoise, RCTs should meet a number of other conditions. They must conform to the canons of scientific methodology, respect accepted scientific principles, be based on knowledge of the investigated disease or problem, ensure adequate laboratory and animal testing, and ensure proper scientific and medical qualifications of investigators.[55] Clinical trials should also have a favorable ratio of potential benefits to risks, meaning that even with the additional risk of research, participation in a clinical trial for a patient would still be a reasonable choice. [56]

It is also unethical for physicians to involve their patients and other prospective subjects in clinical trials without ensuring their free and informed consent. The obvious often needs to be stated: from the very outset patients should be told by their physician that they are being asked to participate in research project. The extent of the disclosure required to validate patients' consent is a complex and widely debated issue.[57] The standard of disclosure insisted on by Canadian courts includes all information considered material for the patient's decision to enter the research.[58] However, even if all necessary information is disclosed, the concern for the validity of the patient's informed consent may still not be fully addressed, since there are several factors that could render this consent invalid. For example, depending on the seriousness of their illness, state of mind, and other factors that make them vulnerable, patients may decide to participate in research for all the wrong reasons: feeling uncomfortable to reject or question their doctor's suggestion to participate, not seeing a big difference between receiving treatment in or outside of the trial, not fully appreciating the implications of the study for themselves,[59] or simply feeling desperate in the face of a looming serious or life-threatening medical condition. A physician's ethical and legal obligation should therefore be to make every effort to ensure that research subjects are provided with all necessary information in a timely fashion and, as far as possible, comprehend and appreciate what the proposed study involves and its potential implications for them.

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[55] This is commonly known as a requirement of "scientific adequacy". See *Nuremberg Code*, from "Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10", Vol. 2, Nuremberg, October 1946 - April 1949. (Washington, DC: US Government Printing Office, 1949). 181 online: <http://ohsr.od.nih.gov/nuremberg.php3> [hereinafter *Nuremberg Code*]; *Helsinki Declaration, supra,* note 43. See also *Bioethics in Canada, supra,* note 13 at 326-327.

[56] See C.Weijer, The Analysis of Risks and Potential Benefits in Research" (1999) NCEHR Communique; 9 (2) & 10 (1) at 16 [hereinafter *Weijer, Analysis of Risks and Benefits*] where he maintains that: "...ensuring that the study has a favorable ratio of potential benefits to risks is the single most important determination made by the REB."

[57] See e.g., D. Pulman, "Subject Comprehension, Standards of Information Disclosure and Potential Liability in Research" (2001) 9 Health L. J. [hereinafter *Pullman*] 113; N. Fontigny, "When Yes Really Means Yes: The Law of Informed Consent in Canada is Revisited" (1995) 4:3 Health L. Rev. 17; see also I. Kennedy, *Treat me Right: Essays in Medical Law & Ethics* (Clarendon Press, Oxford: 1988); B. Mackinnon, "How Important is Consent for Controlled Clinical trials?" (1996) 5:2 Cambridge Quarterly of Healthcare Ethics 221.

In summary, for a RCT to be ethical, it has to be scientifically adequate, adhere to the principle of clinical equipoise, have a positive ratio of benefits to risks, and ensure free and informed consent of research subjects throughout the trial.

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[58] See *infra,* Part II.

[59] See C.W. Lidz *et al.*, "Therapeutic Misconception and the Appreciation of Risks in Clinical Trials" (2004) 58:9 Social Science & Medicine 1689 [hereinafter *Lidz, Therapeutic Misconception*].

5. Are RCTs Unethical or Ethically Imperative?

RCTs are currently conducted in an atmosphere of constant tension between strong criticism on the one hand, and justification and support on the other hand. Critics of RCTs claim that they are inherently unethical, principally because their purpose and design compromise physicians-researchers' prime obligation to their patients and sacrifice the good of individual patients to the good of society or the good of future generations of patients. RCTs' supporters, to the contrary, insist that properly designed and conducted RCTs are not only scientifically and ethically justifiable, but also ethically imperative.[60] This is because physicians' professional and ethical obligation of personalized and compassionate care cannot be separated from the clinical and ethical imperative to give patients scientifically sound and validated treatment. [61] They further suggest that the tension between the two is inherent in the practice of medicine today:

> Where there is uncertainty or definite doubt, or controversy about either the safety or efficacy (or both) of new or established treatments, there is an ethical obligation to test these treatments critically, rather than to prescribe them, day after day, on the basis of custom, fashion, unreliable anecdotal evidence, or clinical rumour. When large numbers of innovative treatments are continuously introduced into clinical practice, as is the case today, rigorous testing of these is ethically mandatory, both for the protection of individual patients and for the just use of scarce resources.[62]

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[60] *Bioethics in Canada, supra,* note 13 at 321; *Piantadosi, supra,* note 36.

[61] *Ibid, Bioethics in Canada,* at 332

[62] *Ibid*.

Both of these views can be supported by compelling arguments, further detailed discussion of which, however, is beyond the scope of this paper. Instead, having assumed that maintaining trust and confidence in the doctor-patient relationship, as well as protecting the rights and interests of patients, as potentially vulnerable individuals, is of significant value to society and therefore, worthy of special protection, this paper examines how these values can be preserved and maintained in the context of clinical research involving humans. What follows is a brief overview of the relevant ethical and policy considerations that underlie physicians' obligations to their patients in RCTs.

C. "Soft Law" on Responsibilities of Physicians in Clinical Research

There is no comprehensive legislative framework in Canada for regulating research involving humans. As a result, health research is governed by professional norms and ethical guidelines, principles of common law, and in some instances by federal and provincial legislation.[63] While a significant body of law deals with relevant issues, such as privacy and confidentiality,[64] discrimination, disclosure of information for purposes of obtaining consent,[65] many areas of clinical practice and research involve complex and rapidly changing issues for which the law, unable to match the pace of change, does not provide answers.[66] Much guidance, therefore, comes from non-legislative sources such as ethics policy statements, guidelines from professional or quasi-governmental bodies, and codes of ethics which, because of their non-prescriptive nature, are commonly referred to as "soft law".[67] The legal status of soft law in Canadian biomedical research and its role in defining obligations that physicians-researchers owe research subjects is a fairly unexplored topic. It can nonetheless be said that, while not having binding power, soft law (1) informs the law regarding the acceptable standard of conduct for physicians and, in the absence of a legal norm on a particular issue, may be the determinative factor in the outcome of a case; and (2) sometimes interprets and completes the law which often provides only very general directions.[68] Analyzing the ethical obligations set out in soft law for physicians who combine medical practice with research is therefore a necessary step towards better defining the scope of physicians' legal obligations to their patients and other research subjects.

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[63] See B. M. Knoppers, "Ethics and Human Research: Complexity or Confusion?" in *The Governance of Health Research Involving Human Subjects* (HRIHS), Law Commission of Canada, 2000 [hereinafter *Governance Report*] at 109, where she observed that "Biomedical research in Canada is governed by law, ethics and professional norms". In Quebec, there are specific norm of the Civil Code that apply to research involving humans. See *Civil Code of Quebec*, S.Q. 1991, c.64. For an overview of the regulation of research involving humans in Quebec see R.P. Kouri, "The Law Governing Human Experimentation in Quebec" (1991), 22 R.D.U.S. 77. For the concise overview of the regulation of the research involving humans in the rest of Canada see K.C. Glass, T. Lemmens, "Research Involving Humans" [hereinafter *Glass & Lemmens*] in J. Downie, T. Caulfield & C. Flood, *Canadian Health Law and Policy,* ed, (2nd ed) (Butterworths: 2002) at 475-79 [hereinafter *Canadian Health Law & Policy*].

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[64] See e.g., E.I. Picard & G.B. Roberson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996) Chapter 1 [hereinafter *Picard & Roberson*]. See also P. Kosseim, "The Landscape of Rules Governing Access to Personal Information for Health Research: A View from Afar" (2003) Health L. J. Special Edition "Health Law in the 21st Century" 113 [hereinafter *Health Law Journal 2003 Special Edition*].

[65] See *Picard & Roberson, ibid,* Chapters 2 & 3.

[66] See A. Campbell, K. C Glass, "The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research" (2001) 46:2 McGill Law Journal, 473 [hereinafter *Campbell & Glass*], where the authors observed at 475 that, "The law ... moves more slowly that either medicine or the public mores. As a result, doctors frequently find themselves operating in an atmosphere of legal uncertainty".

[67] These sources of guidance are also referred to as "extra-legal instruments" and arguably play a more important role in ensuring the ethical conduct of research than legal tools. See *Glass and Lemmens, supra,* note 63, *Glass & Campbell, ibid.*

The existing body of international and national soft law is fairly clear and consistent on the subject of the physician-patient relationship and the responsibilities of the former in clinical research. First and foremost, it strongly emphasizes the paramountcy of patients' welfare and integrity[69] and explicitly states that it is to the patients that physician-researchers' owe their prime responsibility. The *Helsinki Declaration*, for instance, requires that physicians who conduct medical research involving human subjects adhere to the principle: "The health of my patient will be my first consideration."[70] It further stipulates, by reference to the *International Code of Medical Ethics*,[71] that "[a] physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient."[72]

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[68] For example, the legal requirement for physicians to disclose to research subjects all information material to their decision to participate in research is elaborated in Section 2 *"Free and Informed Consent"* of *TCPS, supra*, note 4.

[69] While describing the context of ethical framework, the *TCPS* states at [i.5] that: "the welfare and integrity of the individual remain paramount in human research". The same sentiment is expressed in the subject-centered approach proposed by the *TCPS* at [i.7].

[70] *Helsinki Declaration, supra*, note 43 A (3).

[71] *World Medical Association International Code of Medical Ethics*, as last amended in October 1983 online: <http://www.wma.net/e/pollicy/c8.htm>[hereinafter *International Code of Medical Ethics*].

[72] *Ibid.*

Guidelines and policy documents do not prohibit physicians from conducting research on their patients, but rather set a standard for the permissible involvement of patients in research, namely: research on patients is permissible as long as it benefits them. [73] The *Declaration of Helsinki* clearly states to this effect:

> The physician may combine medical research with medical care, only to the extent that the research is justified by its potential prophylactic, diagnostic or therapeutic value. When medical research is combined with medical care, additional standards apply to protect the patients who are research subjects.[74]

Commentators, who draw a distinction between the ethics of clinical research and clinical practice, suggest that the obligations of physicians to their patients in research differ from those owed in clinical practice. They claim that, while in the ordinary clinical setting physicians have an obligation to provide "optimal medical care" to their patients, in research they only have an obligation not to exploit patients-subjects.[75] According to Miller and Brody, patients are not exploited in research if (1) they are not exposed to the excessive risk of research in the name of science, and (2) they understand that they participate in an experimental project whose purpose is to obtain generalizable knowledge, rather than to benefit them personally.[76]

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[73] It should be noted that the principle stated above is specifically stipulated for the physicians combining medical research with medical care. The general principle of permissibility of medical research involving human subjects states that it "should only be conducted if the importance of the objective outweighs the inherent risks and burdens to the subject". *Helsinki Declaration, supra,* note 43 A18.

[74] *Ibid*, A 28

[75] See F.G. Miller & H. Brody, "What Makes Placebo-Controlled Trial Unethical?" (2002) 2:2 Am. J. Bioethics 3.

Major Canadian and international guidelines and policy documents do not seem to support this view. To the contrary, they indicate that physicians' obligations to their patients in clinical research are at least the same as in ordinary practice. Thus, for instance, *CIOMS International Ethical Guidelines for Biomedical Research Involving Human Subjects* explicitly states that:

> Professionals whose roles combine investigation and treatment have a special obligation to protect the rights and welfare of the patients-subjects. An investigator who agrees to act as physician-investigator undertakes some or all of the legal and ethical responsibilities of the subject's primary-care physician.[77]

Similarly, the *Code of Ethics of the American Medical Association* states that, while doing research, a physician,

> should demonstrate the same concern and caution for the welfare, safety and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation,

and further, in research designed to test the safety and efficacy of treatment,

> [t]he physician must recognize that the physician-patient relationship exists and that professional judgment and skill must be exercised in the best interests of the patient".[78]

As can be seen, the relevant provisions of soft law do not contain any indication that the standard of care required of physicians in clinical research is lower than it is in clinical practice just because physician-researchers have obligations to parties other than their patients. To the contrary, mention of the "special obligation to protect the rights and welfare of the patients-subjects", as in the above-mentioned extracts, or the application of additional standards to protect the patients who are research subjects, particularly while obtaining patients' consent, as in the *Helsinki Declaration*,[79] signals that the scope of physicians' responsibility in research is, in fact, higher than it is in clinical practice.

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[76] *Ibid.*

[77] *CIOMS Guidelines, supra*, note 34 Preamble.

[78] *American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics, E-2.07 Clinical Investigation* online: <http://www.ama.assn.org/ama/pub/category.4301.html>.

Soft law also carefully guards the independence of physicians' judgment and prohibits them from entering any arrangements which could influence their judgment or in any way undermine the trust patients and other research subjects have in it.[80] The *TCPS* states that:

> Researchers hold trust relationships with research subjects, research sponsors, institutions, their professional bodies and society. These trust relationships can be put at risk by conflicts of interest that may compromise independence, objectivity or ethical duties of loyalty. Although the potential for such conflicts has always existed, pressures to commercialize research have led to increased concerns. Researchers, their institutions and REBs should identify and address conflicts of interest -- real or apparent – to maintain the public confidence and trust, discharge professional obligations and ensure accountability.[81]

It is interesting to note that the *TCPS* goes beyond the requirement of disclosure in order to alleviate concerns about a pervasive conflict of interest, suggesting that in such cases an REB “may require that the researcher abandon one of the interests in conflict.”[82]

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[79] See *supra*, note 43, where it states in A 28 that "[w]hen medical research is combined with medical care, additional standards apply to protect the patients who are research subjects".

[80] See *International Code of Medical Ethics*, *supra*, note 71 which states: "A physician shall not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients."

The foregoing brief review of the soft law as it relates to the regulation of physician-patient relationship in clinical research, clearly indicates that its provisions capture the essence of physicians' fiduciary obligation to their patients.

In conclusion, two additional points should be made. The first pertains to the particular importance of ethical norms for regulating the professional conduct of physicians in the area of biomedical research, as well as the importance of sustaining and encouraging free and informed philosophical debate as a means of building and maintaining an effective ethical framework for research involving human subjects. Pelegrino and Thomasma warned future generations more than twenty years ago that:

> Without the reasonable restraints imposed by philosophical critique, medicine and its practitioners may unintentionally convert scientific and medical method into a muddled philosophy of life.[83]

The second point emphasizes the importance of physicians' conscience or “moral intuition”[84] which, notwithstanding the existence of guidelines and regulations, should remain the first practical guide in all complex and challenging situations that they may encounter in their professional endeavors.

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[81] *TCPS, supra*, note 19 [4.1].

[82] *Ibid*.

[83] E.D. Pelegrino & D.C. Thomasma, *A Philosophical Basis of Medical Practice*, O.U.P., 1981, at 8-9.

II. FIDUCIARY LAW AND DOCTOR-PATIENT RELATIONSHIP

> ...[P]erhaps the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature.
>
> *Norberg v. Wynrib,* per McLachlin, J[85]

The ultimate purpose of this chapter is to describe the state of the law as it relates to the fiduciary obligations of physicians in clinical research. Very little case-law deals specifically with obligations of physicians-researchers in a clinical research. Therefore, in order to understand the nature and scope of this obligation, one needs to extrapolate from (1) the doctrine of fiduciary law, (2) existing case-law on the fiduciary duties of physicians in general, and (3) how courts describe physicians' duties in cases where they encounter individuals for purposes other than treatment.

A. Fiduciary Law: Main Characteristics and Principles

1. Fiduciary Doctrine

The law defines a fiduciary as a person entrusted with power or property to be used for the benefit of another and by virtue of his position, is able to affect the beneficiary's interests.[86] Fiduciaries usually have specialised

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[84] J. Mason, R. McCall Smith, *Law and Medical Ethics,* 4th ed, (Butterworths, 1994) at [hereinafter *Law and Medical Ethics*] at 7.

[85] *Supra,* note 1, at 271.

[86] See P. D. Finn, *Fiduciary Obligations,* (Sydney: The Law Book Company Limited, 1977) [hereinafter *Finn, Fiduciary Obligations*]; J. C. Shepherd, *The Law of Fiduciaries,* (Toronto: Carswell, 1981) [hereinafter *Shepherd*], A. W. Scott, "The Fiduciary Principle" (1949) 37 Cal. L.

knowledge or expertise. Their job requires judgement and discretion. Often the party that the fiduciary serves cannot effectively monitor the fiduciary's performance. The fiduciary relationship is, therefore, based on dependence, reliance, and trust.[87] The law strives to protect the interests of individuals in a dependent position and the trust and confidence they repose in others within a given context. The policy underlying fiduciary law is therefore animated by a desire to preserve and protect the integrity of socially valuable and necessary relationships arising from human interdependency.[88] Paul Finn explains the role of fiduciary law as follows:

> It has been used, and demonstrably used, to maintain the integrity, credibility and utility of relationships perceived to be of importance in a society. And it is used to protect interests, both personal and economic, which a society perceived to deem valuable.[89]

The law achieves this by holding fiduciaries to an exceptionally high standard of conduct, known as the duty of utmost good faith and loyalty.[90]

The underlying problem with fiduciary law is that, notwithstanding its lengthy history[91] and the fact that in the last three decades, the Supreme Court

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Rev. 541 [hereinafter *Scott*]; E. J. Weinrib, "The Fiduciary Obligation" (1975) 25 U. Toronto L. J. 1, [hereinafter *Weinrib*], J.D. McCamus, "The Recent Expansion of Fiduciary Obligation: Common Themes and Future Developments" 23 E.T.R. 301 and "Prometheus Unborn: Fiduciary Obligation in the Supreme Court of Canada" (1997) 28 Can Business L J 107.

[87] See *Rodwin Strains, supra*, note 16 at 243-44. For a good discussion about the nature of trust in a doctor-patient relationship see J. Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984) at 95-103.

[88] See *Shepherd, supra,* note 86 where he states at 5: "The law of fiduciaries is the legal system's attempt to recognize the more blatant abuses of trust we place in each other."

[89] *Finn, Fiduciary Obligations, supra,* note 86 at 26.

of Canada has considered the existence of fiduciary relationships in various contexts[92], it lacks a general, all-purpose framework around which to organise its application. As the result, the doctrine of fiduciary law is still surrounded by considerable confusion and uncertainty about its definition and proper application. As Sir Anthony Mason notes, fiduciary law is "a concept in search of a principle."[93] The ultimate effect of this is quite significant: there are neither clear guideposts for identifying who should be held to the stringent standard of the duty of utmost faith and loyalty, nor for defining the scope of the fiduciary obligation for each category of fiduciaries and to what extent it should be enforced. As a result, the concept has been misapplied in a variety of circumstances[94], primarily in order to pave the way for imposing an equitable remedy. As La Forest, J explained in *LacMinerals*:

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[90] See M. V. Ellis, *Fiduciary Duties in Canada*, (Don Mills, Ontario: DeBoo, 1988) [hereinafter *Ellis, Fiduciary Duties*], at 1-3: "As a corollary to the heightened degree of loyalty required, the actions of the fiduciary will be viewed with the strictness unknown to most other areas of law".

[91] One of the first decisions to invoke fiduciary law doctrine is considered to be *Keech v. Sandford* (1726), 25 E.R. 223 (Ch.).

[92] *Canadian Aero Service Ltd. v. O'Malley* [1974] S.C.R.592 [hereinafter *Canadian Aero*]; *Guerin v. The Queen,* [1984], 2 S.C.R.335 [hereinafter *Guerin*]; *Frame v. Smith* (1888), 42 D.L.R. (4th) 81 (S.C.C.) [hereinafter *Frame*]; *Canson Enterprises Ltd. v. Bougton & Co.* (1991), 85 D.L.R. (4th) 129 (S.C.C.) [hereinafter *Canson*]; *M.(K.) v. M.(H.)* [1992] 3S.C.R. 6; *McInerney, Norberg, Hodgkinson, supra,* note 1.

[93] A. Mason, 'Themes and Prospects', in P. D. Finn, ed., *Essays in Equity (*Sydney: Law Book Co., 1985) [hereinafter *Finn, Essays in Equity*] at 246. La Forest J. has also stated in *Lac Minerals Ltd. v. International Corona Resources Ltd.,* [1989] 2 S.C.R. 574 [hereinafter *LacMinerals*] at 643 that "[t]here are few legal concepts more frequently invoked but less conceptually certain than that of the fiduciary relationship".

[94] See *Giradet v. Crease and Co.* (1987), 11 B.C.L.R. (2d) 361 (S.C.), wherein Southin, J noted: "The word 'fiduciary' is flung around now as if it applied to all breaches of duty by solicitors, directors of companies and so forth ". See, for example, *Chase Manhattan Bank N.A. v. Israel-British Bank (London) Ltd.,* [1981] Ch. 105, and *Goodbody v. Bank of Montreal* (1974), 47 D.L.R. (3d) 335, (Ont. H.C.). It is generally agreed that both of these cases should have been decided on the basis of unjust enrichment. See *e.g.,* L.I.

> Courts have resorted to fiduciary language because of the view that certain remedies, deemed appropriate in the circumstances, would not be available unless a fiduciary relationship was present. In this sense, the label fiduciary imposes no obligations, but rather is merely instrumental or facilitative in achieving what appears to be the appropriate result.[95]

Another problem with the uncertainty surrounding the fiduciary doctrine lies in its indiscriminate "catch all" use in litigation meaning that, "if other claims are merit-less or no other cause of action exists, a claim of breach of fiduciary duty is often resorted to"[96].

However, even in the absence of an established definition of a fiduciary concept, there are a number of characteristics that run as common themes in discussions by the judiciary and legal commentators on the subject. These characteristics help to form a current and relatively clear picture of the fiduciary relationship and fiduciary duties.

2. Fiduciary Relationship

A fiduciary relationship is commonly described as a relationship of power or, more exactly, a relationship that is marked by an imbalance of power[97]. One

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Rotman, "Fiduciary Doctrine: A Concept in Need of Understanding" (1996) 34:4 *Alta. L. Rev.* 821 [hereinafter *Rotman, Fiduciary Doctrine*].

[95] *LacMinerals supra,* note 93 at 649.

[96] *Rotman, Fiduciary Doctrine, supra*, note 94. See also R.G. Slaght, "Proving a Breach of Fiduciary Duty", *Special Lectures of the Law Society of Upper Canada: Fiduciary Duties* 1990 (DeBoo: 1991)[hereinafter *Slaght and Special Lectures on Fiduciary Duties* respectively], wherein the author noted at 37: "it is the rare beast that now resists including the magic term "fiduciary" somewhere in the claim".

[97] See *Frame, supra,* note 92 per Wilson, J at 136. This idea is commonly described as the 'inequality theory'. A number of other theories are employed to describe a fiduciary relationship,

party, by virtue of undertaking to act on behalf of another and usually having some special knowledge or skills, acquires power and discretion over the interests of the other party who then becomes dependent on the exercise of this power and discretion. There is nothing inherently wrong with the fact that one person holds power and discretion over another, but this situation creates a risk that such power and discretion can be abused by the one entrusted with them.[98] The aim of fiduciary law, therefore, is to ensure that fiduciaries do not abuse their power and discretion by using it either to damage a beneficiary's interests or to profit themselves or any person other than the beneficiary.

Certain categories of relationships, including those of trustees and beneficiaries, parents and children, guardians and wards, solicitors and clients, have been traditionally considered by the courts as fiduciary and used to determine the existence of fiduciary relationships. However, in the past two decades, Canadian courts have imposed fiduciary obligations in new categories of relationships,[99] indicating thereby that the categories of fiduciary relationship are never closed.[100] Indeed, the Supreme Court *in Hodgkinson* recognized that

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such as, for example, property theory, reliance theory, contract theory, unjust enrichment theory and others, see *Rotman, Fiduciary Doctrine, ibid.*

[98] See *Norberg, supra* note 1 at 275 (per McLachlin). See also T. Frankel, "Fiduciary Law" (1983), 71 Cal. L. Rev. 795 wherein the author noted at 809: "[T]he fiduciary must be entrusted with power in order to perform his function."

[99] See *e.g., Hodgkinson, supra,* note 1, where fiduciary obligations were imposed in the context of commercial relationship of a financial advisor and a client; see also *B.(K.L.) v. British Columbia*, [1998] 10 W.W.R. 348 (B.C.S.C.), where the relationship between the provincial government and children in foster care was recognized fiduciary.

[100] The "open-endedness" of fiduciary doctrine thus means that the imposition of fiduciary obligations is not limited to categories of relationships in which a presumption of such an obligation arises. As such, it can arise between parties in a relationship in which fiduciary obligations would not normally be expected.

principles of fiduciary law can be invoked in any relationship where a careful examination of the facts indicates sufficient presence of power, discretion, and influence on the part of the fiduciary, and reliance, vulnerability, trust, and confidence on the part of the beneficiary to support the conclusion that the fiduciary must act selflessly in the interests of the beneficiary in the matter at issue.[101]

The same point of view is strongly supported by academic writers. Thus, for example, Rotman suggests that "[t]he use of categories to determine the fiduciary nature of a relationship runs counter to the very basis of fiduciary doctrine".[102] According to him, if the purpose of fiduciary law is to preserve and protect the integrity of socially valuable or necessary relationships arising from human interdependency, the applicability of fiduciary law should then be decided on the basis of this purpose rather than through the application of any established categories. It follows that determining whether a particular relationship is fiduciary depends on the circumstances peculiar to that relationship which indicate that one party is entitled to expect that the other party will act in its interests. In other words, fiduciary doctrine is situation-specific:

> Everything depends on the particular facts, and such a relationship has been held to exist in unusual circumstances as

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[101] *Hodkinson, supra*, note 1 at 407. See also *Guerin, supra*, note 93, whereas Dickson, J (as he then was) stated at p. 384:

> It is sometimes said that the nature of fiduciary relationships is both established and exhausted by the standard categories of agent, trustee, partner, director, and the like. I do not agree. It is the nature of the relationship, not the specific category of actor involved that gives rise to the fiduciary duty. The categories of fiduciary, like those of negligence, should not be considered closed.

[102] *Rotman, Fiduciary Doctrine, supra,* note 94 at 831.

> between purchaser and vendor, as between great uncle and adult nephew, and in other widely differing sets of circumstances. Moreover, it is neither feasible nor desirable to attempt closely to define the relationship, or its characteristics, or the demarcation line showing the exact transition point where a relationship that does not entail that duty passes into one that does....[103]

The situation-specific nature of fiduciary doctrine has a tremendous effect on the nature of fiduciaries' duties and obligations, the rights and entitlements of beneficiaries, and the overall application of fiduciary rules to specific relations. As Rotman noted, by summarizing the consensus among several academic commentators,

> Even where particular types of relationships have been described by the courts as fiduciary, that does not necessarily entail that every instance of those relationships is fiduciary. Furthermore, not every aspect of a fiduciary relationship is fiduciary.[104]

The fact that a relationship may be fiduciary only for a specific purpose, or in respect of a specific idea, action, or undertaking[105] also makes it clear that it is far more important to look at the particulars of a relationship to ascertain whether and in what aspects it is fiduciary rather than simply observing who the parties to it are.[106]

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[103] *Lloyd's Bank v. Bundy,* [1975] 1 Q.B. 326 (C.A.) at 34. See also *Slaght, supra,* note 96, where the author further explains at 39:

> fiduciary law is concerned not with the identification of circumstances where one party has agreed to do something in the interests of the other but rather with when the court will decide that one party had an obligation to do so, often in the face of a strident protest to the contrary.

[104] *Rotman, Fiduciary Doctrine, supra,* note 94, at 831.

[105] *McInerney, supra,* note 1 at 149. See also *N.Z. Netherland Society 'Oranje' Inc. v. Kuys,* [1973] 2 All E.R. 1222, wherein Lord Wilberforce at 1225 held: "A person... may be in a fiduciary position quoad a part of his activities and not quoad other parts: each transaction, or group of transactions, must be looked at." as cited in *Slaght, supra*, note 97 at 40.

[106] *LacMinerals, supra,* note 93 per La Forest, J at 648. This also makes it impossible to authoritatively determine the totality of relationships that may be deemed to be fiduciary, which

While the situation-specific nature of fiduciary doctrine prevents the fiduciary relation from being precisely defined in the absence of context, that does not preclude a general understanding of fiduciary theory, as evidenced by the indicia developed by the courts for identifying fiduciary relationships, and the list of duties to which such relationships give rise. Thus, pursuant to what is sometimes colloquially referred to as the "rough and ready" test, advanced by Wilson, J in her dissenting judgment in *Frame v. Smith*, a relationship can be described as fiduciary if: (a) it includes the scope for the exercise of some discretion or power by the fiduciary; (b) the purported fiduciary can exercise that power or discretion unilaterally so as to effect the beneficiary's legal or practical interests; and (c) there is a peculiar vulnerability to the exercise of that discretion or power on the part of the beneficiary.[107]

The Supreme Court of Canada adopted and refined the "rough and ready" test in its majority opinion in *Hodgkinson*. The following propositions enunciated by La Forest, J, on behalf of the majority, capture the treatment of this test by the court:

1. Fiduciary duties are a part of a more generalized duty by which the law seeks to protect vulnerable people in transactions with others;[108]
2. The existence of a contract does not preclude the existence of fiduciary obligations;[109] and

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accounts for the open-endedness of the fiduciary doctrine, mentioned above, see *Rotman, Fiduciary Doctrine, supra*, note 94 at 39.

[107] See *Frame*, *supra*, note 92 at 99.

[108] *Hodgkinson*, *supra*, note 1 at 405.

3. Fiduciary obligations can arise outside of fiduciary relationships where, in the circumstances of the particular relationship, one party could reasonably have expected that the other party would act in the former's best interests with respect to the subject matter at issue and, as a result, put him or herself into a position of special vulnerability.[110]

The main difference between the majority and minority views in *Hodgkinson* centered on the role of vulnerability and reliance in establishing a fiduciary relationship. Sopinka and McLachlin, JJ, on behalf of the minority, insisted that a beneficiary should be "at the mercy" of a fiduciary, suggesting thereby a need for total reliance and dependence in order for a fiduciary obligation to arise.[111] The majority, on the other hand, pointed out that reliance, for example, in an advisory context "does not require a wholesale substitution of decision-making power… [t]his is simply too restrictive."[112] This divergence reflects generally the views that continue to fuel debate on the issue.

In addition to the Wilson, J's indicia, the Supreme Court of Canada also uses other factors in determining whether a fiduciary relationship exists, including trust,[113] an undertaking by the fiduciary to act in the best interests of

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[109] *Ibid.* at 407. *But* see *Cadbury Schweppes Inc. v. FBI Foods Ltd.*, [1999] 1 S.C.R. 142, where the court noted: "The fact that the parties are dealing at arm's length or have reduced their agreement to a written contract are important countervailing considerations."

[110] *Hodgkinson, ibid.* at 412-13.

[111] *Ibid.* at 467-68.

[112] *Ibid.* at 382.

[113] See *e.g., Norberg, supra,* note 1 at 486.

the beneficiary[114] and a corresponding expectation on the part of the beneficiary[115]. According to Slaght, the benefit of LaForest, J.'s treatment of the "rough and ready" test is that each of the indicia can be viewed simply as guides and not categories in which a relationship should fit in order to be recognized fiduciary. He further maintains that:

> In truth, no one factor will determine the issue and the fact that the evidence does not establish the presence of one of the factors, for example, "vulnerability", should not prevent a court from finding a fiduciary relationship in a given case. What is starkly clear in the formulation of this test is that, ultimately, the court is imposing the obligation, yet the constraint is the need to show by the evidence that the parties would reasonably expect their relations to be governed by the standards so imposed.[116]

In this paper, all above-mentioned indicia will be used to determine whether a fiduciary obligation arises on the part of physicians-researchers in the context of a clinical trial. The ultimate purpose of this exercise is to see whether the actual circumstances of this relationship are such that patient-subjects are entitled to expect that the physician-researchers will act in their interests in and for the purposes of the relationship

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[114] *Guerin* [1984] 2 S.C.R.335.

[115] See *Hodgkinson*, *supra*, note 1, where LaForest, J at 409, states a fundamental test for determining the existence of a fiduciary obligation as follows: "[G]iven all the surrounding circumstances could one party reasonably have expected that the other party would act in the former's best interests with respect to the subject matter at issue". He then continues to say that "...what is required is evidence of mutual understanding that one party has relinquished its own self-interest and agreed to act solely on behalf of the other party", *supra*.
See also *LacMinerals*, *supra*, note 93, at 663, also per La Forest, J.

[116] *Slaught, supra,* note 96, at 48. See also P.D. Finn, "The Fiduciary Principle" in T.G. Youdan, ed., *Equity, Fiduciaries and Trusts* (Toronto: Carswell, 1989) [hereinafter *Finn, Fiduciary Principle*] at 64 as quoted by La Forest J. in *LacMinerals*, *supra,* note 93 at 648, where he maintained,

> The only relevant consideration is whether the nature of the relationship is such that it ought to be considered fiduciary.
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> ...
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> [a]scedancy, influence, vulnerability, trust, confidence or dependence doubtless will be of importance in making this out, but they will be important only to the extent that they evidence a relationship suggesting that entitlement.

See also *Guerin*, *supra,* note 92 at 384-85, where it has been held: "The only relevant consideration is whether the nature of the relationship is such that it ought to be considered fiduciary".

3. Fiduciary Duties

As already noted, a fiduciary duty demands "utmost good faith" (*uberminae fides*), which itself imports the requirement that the fiduciary acts toward the beneficiary with a heightened sense of loyalty and fidelity. In practical terms this means that fiduciaries should scrupulously avoid placing themselves in a real or potential conflict of interest; that is, in a situation where their roles, interests, or activities could compromise their loyalty or judgement.[117] The avoidance of conflict of interest can be subdivided into a non-exhaustive list of specific requirements, including: (1) complete disclosure of any material information, (2) prohibition against personal gain[118], and (3) prohibition against serving two masters.[119]

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[117] See *Canadian Aero, supra*, note 92 at 606, whereas the court characterized fiduciary obligation as the one which "betokens loyalty, good faith and avoidance of a conflict of duty and self-interest." For a discussion on fiduciary duty see P.D. Maddaugh, "Definition of Fiduciary Duty" in *Special Lectures of the Law Society of Upper Canada 1990*, (DeBoo: 1991) 15.

[118] In *City of Toronto v. Bowes,* (1854), 4 Gr.49 Chancellor Blake expressed this point in the following terms at 503:

> The settled rule is, that he who is entrusted with the business of others cannot be allowed to make such business an object of interest to himself.

Fiduciary law generally does not allow fiduciaries to gain personally in the conduct of their fiduciary duties, although fiduciaries may receive compensation for their services. See *e.g.*, The Right Honourable Sir Robert Megarry, "Historical Development" in *Special Lectures on Fiduciary Duties, supra,* note 96 at 1-6.

[119] *Ibid.* at 1-7.

The strict and uncompromising nature of the fiduciary obligation is demonstrated by the following corollary principles: (1) a fiduciary owes a single-minded loyalty to the interests of the beneficiary to the detriment of his own interests;[120] (2) a gain for the beneficiary does not justify a gain acquired for the fiduciary;[121] (3) good faith does not validate a breach of a fiduciary obligation; and (4) causality is not analyzed by the court where there has been a breach, meaning that the fiduciary is not entitled to allege that the loss resulting from the breach would have occurred notwithstanding the breach. Equity also explicitly prescribes that "if and when choices are to be made, they will be made by the fiduciary".[122] It follows that fiduciaries are not normally allowed to delegate their fiduciary responsibilities to others.[123] In attempting to add practical substance to the concept of a fiduciary obligation, various authors have sought to list the duties to which such an obligation can give rise. For example, Krever, J and

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[120] See *Keech v. Sanford, supra,* note 91; see also *Ellis, supra,* note 90, at 1-2.

[121] This is known as "an incidental benefit to the beneficiary" rule which means that if a fiduciary acts with the objective of deriving an improper advantage, he cannot validate an invalid act by showing that the act benefited the beneficiary. See M.V. Ellis, *Professional Fiduciary Duties* (Scarborough: Carswell, 1995) at 20-42 [hereinafter *Ellis, Professional Fiduciary Duties*].

[122] *Finn, Fiduciary Obligations, supra,* note 86 at 16.

[123] See D. Waters, *The Law of Trusts in Canada,* 2nd ed. (Toronto: Carswell, 1984) wherein at 696 he noted:

> The rule adopted by equity towards persons occupying fiduciary positions was that such a person cannot delegate his duties, whatever they are. The Latin maxim was clear and succinct: *delegatus non protest delegare*, ...and this includes both third parties and co-trustees.

See also E.E. Gillese, *The Law of Trusts* (Ontario: Concord, 1997) at 134-36 for non-delegation rule in doctor-patient relationship.

Lewis[124] identify three main duties imposed on professionals in the context of a fiduciary relationship:

1. the duty of full disclosure;
2. the duty to maintain all confidences; and
2. the duty to avoid situations where a conflict of interest arises, which may undermine the professional person's obligation to act in client's best interest.

Finn suggests another, more detailed classification which includes a duty:

1. not to delegate discretion;
2. not to act under another's dictation;
3. not to put "fetters" on discretions;
4. to consider whether a discretion should be exercised;
5. not to act for one's own benefit, or for the benefit of any third person;
6. to treat beneficiaries equally where they have similar rights;
7. to treat beneficiaries fairly where they have dissimilar rights; and
8. not to act capriciously or totally unreasonably.[125]

Although not purporting to exhaust the content of the fiduciary obligation, these two classifications together canvass the range of fiduciary duties that, to a greater or lesser extent, can be applied to all categories of fiduciaries. Armed with the foregoing, the next step is to examine the scope of physicians' fiduciary duties to their patients.

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[124] "Fiduciary Obligations and the Professions" in *Special Lectures on Fiduciary Duties*, *supra*, note 96 at 282-90.

[125] *Finn, Fiduciary Obligations*, *supra,* note 86.

B. Fiduciary Duties of Physicians

Physicians have been traditionally viewed by Canadian courts as owing a fiduciary obligation to their patients.[126] However, physicians have only been held liable as fiduciaries in limited circumstances. Courts either have been reluctant, or have not had occasion to consider the full range of duties to which physicians can be held. What follows is a survey of some of the leading cases on the subject.

Norberg[127] is one of the most recent cases which considered the issue of a physician's fiduciary responsibility. Although the Supreme Court of Canada found no fiduciary liability on the part of the physician who had prescribed drugs to an addictive patient in exchange for sexual favours in this case,[128] it nevertheless reaffirmed the fiduciary nature of a physician-patient relationship and, in its minority decision delivered by McLachlin, J, provided useful insights into the concept of fiduciary obligation. As McLachlin, J explained, although the doctor-patient relationship can be conceptualised as a creature of contract or tort, its most fundamental characteristic, rooted in the trust inherent in the relationship, is its fiduciary nature. That is:

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[126] See *e.g.*, *Kenny v. Lockwood* [1932] O.R.141 [hereinafter *Kenny*] where Hodgkins, J.A. stated, at 155, that the relationship of a physician and a patient is the one in which "trust and confidence" must be placed in the physician. See also *Henderson v. Johnston* [1956], O.R. 789 [hereinafter *Henderson*], where the court characterised the physician-patient relationship as "fiduciary and confidential". The earliest Canadian case that recognized the fiduciary nature of the physician-patient relationship is *Rowe v. Grand Trunk Railway Co.* (1866), 16 U.C.C.P. 500 at 506.

[127] *Supra*, note 1. For the commentary on this case, see M. A. Marshall, "Civil Action for Damages for Sexual Abuse by Physicians" (1993) 1 Health L J 85; J. Cowie, "Difference, Dominance, Dilemma: A Critical Analysis of Norberg v. Wynrib" (1994) 58 Sask. L. Rev. 357

[128] Other courts held doctors liable for breach of fiduciary duty arising from sexual abuse of their patients, see *e.g.*, *C.(C.D.) v. Starzecki* (1995, [1996]) 2 W.W.R. 317 (Man Q.B.); *M(D.M.) v. Pilo*, [1996] O.J. No. 938 (QL) (Gen. Div.) and the recent case of *Mussani v. College of Physicians and Surgeons of Ontario* [2003] O.J. No 1956 para. 23 (QL).

> The foundation and ambit of the fiduciary obligation are conceptually distinct from the foundation and ambit of contract and tort... In negligence and contract the parties are taken to be independent and equal actors, concerned primarily with their own self-interest. Consequently, the law seeks a balance between enforcing obligations by awarding compensation when those obligations are breached, and preserving optimum freedom for those involved in the relationship in question. The essence of a fiduciary relationship, by contrast, is that one party exercises power on behalf of another and pledges himself or herself to act in the best interests of the other... The fiduciary relationship has trust, not self-interest, at its core, and when breach occurs, the balance favours the person wronged.[129]

McLachlin, J further stated with regards to the fiduciary nature of the doctor-patient relationship:

> I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship – trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise this power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them required.[130]

In holding that the doctor-patient relationship is a fiduciary one the Supreme Court of Canada in *Norberg* affirmed the position it had taken a week earlier in *McInerney.*[131] The latter case involves a patient who requested her physician to provide her with a copy of her entire medical file. The physician complied in part, refusing however to give her copies of reports produced by other physicians on the ground that they are the property of those physicians.

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[129] *Norberg, supra,* note 1, at 487-488.

[130] *Ibid,* at 486.

[131] *Supra*, note 1.

According to the Court, the fiduciary nature of the physician-patient relationship gives rise to the duty on the part of physicians to act with utmost good faith and loyalty, to hold information received from or about a patient in confidence,[132] and to make proper disclosure of this information to a patient. The Court then used the fiduciary concept to expand the physician's obligation to include the duty "to grant access to the information the doctor uses in administering treatment".[133] As La Forest, J explained on behalf of the Court:

> The fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in his or her records. ... information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. ... The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.[134]

Courts also require, as a part of the fiduciary obligation that physicians disclose to patients information material to their consent to treatment. The

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[132] *Ibid.* at 149; see also *R. v. Osolin* (1993), 109 D.L.R. (4th) 487 (S.C.C.) per L'Heureux-Dube; *R. v. O'Connor* (1995), 130 D.L.R. (4th) 235 (S.C.C.); and *R. v. Dersch*, [1993] 3 S.C.R. 768 at 777-78. For a thoughtful discussion on this matter see B. Friedland "Physician-Patient Confidentiality", (1994) 15 J. Legal Med. 249.

[133] See *McInerney, supra,* note 1, at 150; for a comment on this case see B. Dickens, "Medical Records -- Patient's Right to Receive Copies -- Physician's Duty of Disclosure: *McInerney v. MacDonald* ", (1994) 73 Can. Bar. Rev. 234.

[134] *Ibid. McInerney.*

Supreme Court of Canada considered the requirement of disclosure in *Reibl v. Hughes*,[135] a case involving a patient who suffered a massive stoke which left him partially paralyzed as a direct result of surgery. The patient had consented to the surgery, but subsequently claimed that his consent was not informed since the surgeon had not told him about significant risks associated with the procedure. Chief Justice Laskin, delivering a unanimous decision of the Court, supported the patient's claim and firmly stated that doctors have a legal duty to advise their patients of the material risks, and other material information associated with proposed treatment prior to obtaining consent.[136] He described this obligation as follows:

> [T]he decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.[137]

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[135] (1980) 2 S.C.R. 880 [hereinafter *Reibl]*; see also *Hopp v.Lepp* (1980), 2 S.C.R. 192 [hereinafter *Hopp*]. The principle itself was established a long before this judgment, when a prominent American jurist Justice Cardozo stated in *Schloendorff v. New York Hospital*, 105 N.E. (N.Y. C.A. 1914) 92 at 93 and 129-30 respectively: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" and "a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages".

[136] For an excellent insight into the notion of material information and other aspects of informed consent, see B.M. Dickens "Informed Consent" in J. Downy & T. Caulfield, *Canadian Health Law and Policy, supra,* note 63 at 129-156.

Lambert, J of the British Columbia Court of Appeal subsequently applied the concept of fiduciary law to explain the duty of disclosure in *Arndt v. Smith*:[138]

> [T]he duty of disclosure of material risks or of special or unusual risks is not like an ordinary duty of care in negligence, because it is not set by the standard of a reasonable medical practitioner, but is more similar to a fiduciary duty of disclosure, where the standard is set by utmost good faith in the discharge of an obligation by a person in the position of power and control to a person who is vulnerable, in a position of dependency, and is known by the doctor to be in a position of reliance.[139]

The fiduciary concept has also been applied in the context of physicians' conflict between fulfilling professional responsibilities – and in this sense, fiduciary duties to their patients – and considering either third parties' or physicians' own interests. Although there are no recent cases directly addressing the matter in Canadian practice, the courts' attitude toward the issue of physicians' conflict of interest has been clearly stated on a number of occasions.[140] For example, in *Henderson,*[141] a case dealing with fee-splitting, the Ontario High Court emphasised the fiduciary nature of the doctor-patient relationship and stated that:

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[137] *Reibl, supra,* note 135 at 884. For a discussion on the effect of the decision in *Reibl,* see G.B. Robertson "Informed Consent 20 Years Later" in *Health Law Journal 2003 Special Edition, supra*, note 64 at 153.

[138] [1997] 2 S.C.R. 539. See also *McInerney, supra,* note 1. For a radically different approach see the High Court of Australia case of *Breen v. Williams* (1996) 186 CLR 71.

[139] *Ibid. Arndt v. Smith,* at 713.

[140] See *e.g. Canadian Aero, supra,* note 92 at 606, wherein McLachlin, J held that the freedom of the fiduciary is limited by the obligation he or she has undertaken– an obligation which "betokens loyalty, good faith and avoidance of a conflict of duty and self-interest".

[141] *Supra,* note 126.

> The medical practitioner, like the lawyer or other professional adviser, is bound … to see … that in no circumstance will he allow his professional duty to come into conflict with his personal interests. And when a patient consults his physician he is entitled, in equity, to assume that this adviser has no pecuniary interest in the surgical operation he advises or in the choice of the surgeon or in the amount of the proposed surgeon's fee. If the medical adviser has a pecuniary interest – and a fee-splitting arrangement is such an interest -- he must disclose it or fail in the discharge of his duty to his patient, and by failing in that way he acts illegally, in my opinion.[142]

Given the foregoing, the decision of the California Supreme Court in *Moore v. Regents of the University of California*[143], which is discussed later in more detail, perhaps presages how Canadian courts will deal with allegations of conflict of interest involving physicians and patients. In that case a doctor, without his patient's knowledge or consent, used a sample of the patient's tissue in a research project that led to the development of a profitable cell line. The patient sued for damages and the doctor, together with other defendants named in the action, applied to the court to have the action summarily dismissed. The court held that, on the facts as alleged, the plaintiff had a good cause of action based on a lack of informed consent and breach of fiduciary duty. It concluded that, when seeking a patient's consent for a medical procedure, the doctor has a fiduciary duty to "disclose personal interests unrelated to the patient's health, whether research or economic that may affect his medical judgement".[144]

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[142] *Ibid.* at 534 (Ont. H. C.). In a more general context of the professional advisory relationship the Supreme Court of Canada in *Hodgkinson, supra* note 1 at 387 has observed that:

> ... [i]t would be surprising indeed to expect an advisee to protect himself or herself from the abuse of power by his or her independent professional advisor when the very basis of the advisory contract is that the advisor will use his or her special skills on behalf of the advisee.

[143] 793 P. 2d 479 (Cal. 1990), *cert.* denied, 111 S. Ct. 1388 (1991) [hereinafter *Moore*].

Finally, several Canadian courts have also held that the duty to disclose medical mistakes is grounded in the fiduciary nature of the doctor-patient relationship.[145]

Based on the foregoing case-law analysis, the duties imposed by Canadian courts on doctors appear to be based on traditional fiduciary obligations and include:

1) a duty to disclose material information associated with proposed treatment prior to obtaining patient's consent for treatment;
2) a duty to disclose medical mistakes;
3) a duty to protect the confidentiality of patient's information and to provide a patient with access to his medical records; and
4) a duty to avoid conflict of interest.

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[144] *Ibid.* at 485.

[145] See e.g. *Vasdani v. Sehmi*, [1993] O.J. No. 44 (QL) (Gen Div.); *Gerula v. Flores* (1995), 126 D.L.R. (4th) 506 (Ont. C.A.). For the discussion of the duty to disclose medical mistakes see generally *Picard & Roberson, supra,* note 64 at 170-72.

C. Fiduciary Duties of Physicians in Clinical Research

> Despite the fact that human experimentation has accompanied the practice of medicine from very old times of antiquity, the current concept of planned medical research has not been really presented to the court.
>
> *H.K. Beecher.*[146]

To date, Canadian courts have had very few chances to address the issue of physicians' duties as clinical investigators to research subjects. In fact, there is no reported Canadian case that explicitly imposes fiduciary obligations on physician-researchers. The state of Canadian law in this area has been described by some as undeveloped with the result that, biomedical research involving humans is governed by law primarily directed to purposes other than research.[147]

Cases commonly cited in the discussion of the researcher-subject relationship are concerned with insufficient disclosure of information, primarily risks in respect of research procedures.[148] In this context, courts invoke the concepts of battery and negligence which they generally view as regulating the doctor-patient relationship and protecting patients' rights in the medical setting. As Banks observed:

> The law of battery and the law of negligence are the predominant legal mechanisms for protecting patients in their interactions with physicians. In both battery and negligence consent operates as a

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[146] *Beecher, Research & Individual, supra*, note 6 at 165.

[147] B. Dickens, "Legal Issues: Governance Relations in Biomedical Research, in *Governance Report supra*, note 63 at 93.

[148] See e.g., *Halushka v. University of Saskatchewan* and *Weiss v. Solomon infra*, nn.159 & 166 respectively and accompinying text.

> boundary to distinguish treatments that are legally valid from those that are tortious. The law recognizes that treatments may be legally valid though perhaps medically ineffective or even harmful in the result. What distinguishes the misadventure from the unlawful conduct is often whether the patient gave consent to the procedure or treatment.[149]

While not denying that the concept of standard of care plays an important role in regulating physicians' conduct, it is nonetheless arguable that medical jurisprudence has focused too heavily on the law of negligence in its analysis of physicians' duties. Banks advocates redressing the balance by giving equal attention to analyzing these duties with reference to the duty of loyalty under the law of fiduciary obligation. As he explains:

> In Canadian jurisprudence, we are accustomed to beginning our analysis of informed consent within the context of battery and negligence. But in concrete relationships between physicians and patients, the relationship begins with its fiducial qualities and only rarely and tragically ends up in issues of battery and negligence. The Courts must keep this fact in mind to ensure that the remedies they offer are sufficient for corrective justice.[150]

According to Banks, this approach should allow for a more comprehensive analysis of the duties of physicians and better protection for patients. The question this raises is whether there is a sufficient basis in the current law to suggest that physicians-researchers are fiduciaries vis-à-vis their patients and other research subjects in clinical research. The answer, in turn, may be informed by the analysis of the following cases: *Moore v. Regents of the*

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[149] T. M. Banks, "Misusing Informed Consent: A critique of limitations on research subjects' access to genetic research results" (2000) 63 Sask. L. Rev. 539, at 553 [hereinafter *Banks*].

[150] *Ibid.*at 572.

University of California, Halushka vs. University of Saskatchewan, Weiss v. Solomon, Parslow v. Masters, and Law Estate v. Simice.

1. Moore v. Regents of the University of California

Moore, the facts of which have been described earlier, [151] appears to be the first case in which a physician-researcher's fiduciary obligation was discussed. This decision raises a number of important issues relevant to a discussion of the duties of physician-researchers.

First, the California Supreme Court held in this case that a physician-researcher breaches his fiduciary duty when he fails to disclose a material financial interest that could affect his judgment.[152] Thus, in addition to disclosing the risks associated with treatment, the case imposed on physician-researchers a requirement to disclose any personal interest that might affect their medical judgment prior to obtaining a patient's consent:

> (1) a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment; and (2) a physician's failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.[153]

Panelli, J in his majority decision held that the concept of informed consent is broad enough to encompass this requirement. He justified such an inclusion by employing a patient-centered analysis of the concept of informed consent and referring to an earlier decision of the court in *Cobbs v. Grant*[154]: "The scope of physicians' communication to the patient ... must be measured by the patient's need, and that need is whatever information is material to the decision".[155]

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[151] *Supra,* n. 143 and accompanying text.

[152] *Ibid.* at 485-86.

[153] *Ibid.* at 488.

Second, *Moore* is informative for its discussion of the conflict of interest which inevitably arises for physicians who combine treatment of patients with research procedures on them. Panelli, J emphasized that it is not against the law for a physician to conduct research in the same area in which he practices. In fact, he recognized the value of combining clinical practice with research for the progress of medicine.[156] And yet, Panelli, J also warns against situations in which a physician's professional judgment may be inappropriately influenced by his own research interests, thereby possibly endangering the quality of his patients' care and their safety. He goes on to explain that, the decision-making in the treatment context involves weighing the benefits and risks of a medical treatment or a procedure to an individual patient. According to Panelli, J, the patient's interests and desires should be determinative in such a decision-making process. In the research setting, the risks and benefits of a treatment or procedure are also weighed against the requirements of the research protocol, which sometimes renders the decision-making process more difficult and places the medical researcher in an unavoidable conflict of interest.[157]

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[154] (1972) 8 Cal. 3d 229, 242 [104 Cal. Rptr. 505, 502 P. 2d 1.

[155] *Ibid*. at 245

[156] See *Moore, supra,* note 143 at 914.

Finally, the court in *Moore* implied that the existence of fiduciary duties depends on the existence of the doctor-patient relationship. The court held that the University of California, its other researchers, and a biotechnology company, all of whom were named as defendants in this case, were not liable for breaching a fiduciary duty because they were not physicians standing in a fiduciary relationship with the plaintiff. The plaintiff did not have direct dealings with them, except as arranged by the defendant physician.[158]

The decision in *Moore* is obviously not binding in Canada. However, Canadian courts may find the California Supreme Court's reasoning persuasive if and when the issue of a physician-researcher's responsibilities to his patient arises in Canada. Given the significant amount of clinical research and the incredible pace of its development, it is now only a matter of time.

2. Halushka vs. University of Saskatchewan

The leading Canadian case on the issue of a physician-researcher's obligations to a research subject is the Saskatchewan Court of Appeal decision in *Halushka*[159]. The plaintiff in this case volunteered for a medical experiment in which he was given a new anaesthetic. During the procedure a catheter was inserted in his heart and, as a result, he suffered a complete cardiac arrest but was ultimately resuscitated. The plaintiff had been given only a cursory explanation of the procedure and had not been told of the risks involved in the administration of anaesthetic. The court held that the defendants, physicians-researchers performing clinical experiments, had a duty to give a "full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent."[160] The court further stated that the physician-researchers' duty of disclosure to research subjects was "at least as great, if not greater than the duty owed by an ordinary physician or surgeon to his patient."[161] Also noteworthy is that the court recognized no exceptions to the common requirement of disclosure applicable in a therapeutic setting. This is because, according to the court, the researcher

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[157] *Ibid.* at 915.

[158] The court concluded, however, that they could be secondarily liable. *Ibid.* at 486.

[159] [1966] 53 D.L.R. (2d) 436 (C.A.) [hereinafter *Halushka*].

> ...does not have to balance the probable effect of lack of treatment against risk involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research."[162]

It follows that the extent of disclosure required from a researcher in clinical research is greater than that expected from a doctor in a traditional therapeutic setting. This case is commonly viewed as establishing the Canadian standard for informed consent in research.[163]

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[160] *Ibid.* at 445.

[161] *Ibid.*

[162] *Ibid.* at 443-444.

Although *Halushka* was decided on the basis of trespass and negligence principles, in *obiter dictum*, the court adopted the language of Hodgins, J.A. in *Kenny* to describe the relationship between researcher and research-subjects as one of "trust and confidence".[164] Whether a physician and a healthy volunteer form a doctor-patient relationship while participating in a clinical experiment that holds no promise of a benefit for the latter was not specifically addressed by the court, but it nevertheless proceeded on the assumption that the parties were in a doctor-patient relationship. Not knowing the court's reasoning on this point, one can only speculate that this assumption was based on the court's recognition of the fact that a physician establishes a doctor-patient relationship with anyone he interacts with professionally regardless of the reason for the interaction.[165] Additional or alternative reason for that may include the fact that clinical experimentation in the early 1960s had not yet become a distinct type of occupation for physicians and other medical practitioners, but was rather seen as a necessary, if not an entirely common part of medical practice. Perhaps based on that reason, the court attempted to analyze the case with reference to principles akin to those of fiduciary law.

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[163] See *e.g.*, *Canadian Health Law & Policy, supra*, note 63 at 485.

[164] *Kenny, supra*, note 126 at 519-20, as cited in *Halushka, supra*, note 159 at 443.

[165] This reasoning seems to be adopted by the court in the case of *Parslow v. Masters*, which is discussed later.

3. *Weiss v. Solomon*

In *Weiss v. Solomon*[166] the Quebec Superior Court also considered a claim of insufficient disclosure brought on behalf of the individual who participated in non-therapeutic research.[167] A patient who had just undergone cataract surgery was invited by his surgeon to participate in a hospital research study conducted by another physician. Although the study examined the ability of eye drops to reduce a frequent side-effect of a cataract surgery, the patient was told that it would yield no therapeutic benefit for him. As a result of being injected with fluorescent dye, a procedure used to verify the effect of eye drops, the patient suffered a cardiac arrest and died after an unsuccessful attempt to resuscitate him. Although the risk of this happening was very small, the Court held that both, the physician-investigator and the hospital (through its research committee) were negligent in (1) failing to inform the research subject of this risk, (2) including him in this clinical trial despite the known history of his heart condition and (3) once having included him in the trial, not ensuring the availability of adequate resuscitation means.

In defining the standard of disclosure, the court attempted to further clarify the standard established earlier in *Halushka*[168] by stating that "[t]he duty to inform in matters relating to purely scientific experimentation is the most exacting possible",[169] meaning that all, even rare or remote risks, especially if they entail serious consequences, should be disclosed. In considering the scope of legal liability for researchers and institutions conducting non-therapeutic procedures on subjects, the court held that they have a duty to protect the safety of research subjects throughout the research study. As an extension of this duty, the court imposed on investigators and hospitals (through their review committees) a duty to screen subjects for conditions that preclude them from participating in a given clinical trial. Without giving specific criteria for screening, the court nevertheless held that subjects with known conditions should either be excluded or included only under strict precautions.[170]

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[166] 48 C.C.L.T. 280 [hereinafter *Weiss*].

[167] For commentary on the decision in *Weiss*, see B. Freedman & K. C. Glass, "*Weiss v. Solomon*: A Case Study in Institutional Responsibility for Clinical Research" (1990) 18:4 Law, Medicine & Health Care 395 [hereinafter *Freedman & Glass, Weiss v. Solomon*].

[168] *Halushka*, along with *Reibl* and *Hopp,* was cited with approval in this decision.

Following in the footsteps of *Halushka*, the court reaffirmed the standard of practice to which researchers are held in performing non-therapeutic research. It stated that, a physician-researcher has a duty to undertake research with the same skill and diligence as a reasonable and prudent physician in clinical practice. The court emphasized that in cases where the experimental procedure is described in a research protocol and involves a significant risk to the health and well being of research subjects, this standard is particularly stringent.[171] It is interesting to note that the surgeon who operated on the patient, knew about his heart condition and effectively recruited him into the study, was found not to have played a determinative role in either the study or the patient's decision to participate in it, and as a result, was found not to share responsibility for his death.[172] Given the trust and reliance patients place on the opinion and advice of their physicians, it is reasonable to anticipate that recruiting physicians' legal responsibility for harm to their patients caused in the course of clinical trials will again arise as an issue.

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[169] *Weiss, supra*, note166 at 282. See generally *Picard & Robertson*, *supra*, note 64 at 150.

[170] *Ibid. Weiss* at 285.

[171] *Ibid.* at 287.

4. *Parslow v. Masters*

The nature of the doctor-patient relationship and, in particular, when and in what circumstances a relationship arises, was subsequently considered by the Saskatchewan Court of Queen's Bench in *Parslow v. Masters.*[173] Elaine Parslow, who was receiving long-term disability benefits under a group insurance policy, was requested to be examined by Dr. Masters, an independent medical practitioner. Based on the physician's report, the insurance company stopped paying disability benefits. Mrs. Parslow requested a copy of the report, but was refused by both the doctor and the insurance company. Mrs. Parslow claimed a right of access to her medical information, especially to personal information voluntarily disclosed by her to Dr. Masters and applied to the court for an order requiring the doctor and insurance company to provide her with this information. The issue, therefore, was whether a person who submits to an independent medical examination at the request of an insurer is entitled to receive a copy of the medical report that the doctor prepares for the insurer. The court, relying on the La Forest, J's reasoning in McInerney, decided that because the parties were in a doctor-patient relationship, which is fiduciary in nature, Mrs. Parslow should have access to the physician's report. [174] It based its decision solely on the concept of fiduciary obligation.

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[172] *Ibid.* at 282.

Among the court's conclusions and findings, two are particularly relevant to a discussion of physicians' fiduciary obligations. The first conclusion entails an extended interpretation of the doctor-patient relationship, which includes doctor-patient encounters whose purpose is not to provide professional advice or treatment but rather, as in the case before the court, to evaluate the medical condition of individuals in order to determine their entitlement to benefits under an insurance policy. Despite the fact that the examination was conducted outside the scope of the usual doctor-patient relationship, the Court decided that a doctor-patient relationship was, in fact, created and fiduciary duties established on the basis of Mrs. Parslow's disclosure of her personal information to Dr. Masters. In particular, the Court stated that:

> While it is true that Great-West paid for the medical report in respect of Parslow, it is also true that Parslow was required to disclose private and personal information about herself to enable Masters to prepare the report. In this respect, the physician-patient relationship was created, even if the purpose of the medical consultation with Masters was not to enable him to advise Parslow and prescribe the course of treatment for her. Masters was required to examine Parslow to give an opinion on her condition to enable Great-West to evaluate her entitlement to benefit under the insurance policy during the pendency of a claim

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[173] [1993] 6 W.W.R. 273 [hereinafter *Parslow*]

[174] The order was not granted as requested due to a procedural rule.

> under the policy. To suggest there is no fiduciary relationship because the physician attendance was not for the purpose of providing professional services to Parslow is to construe the nature of the physician-patient relationship too narrowly.[175]

In fact, the court did not see any essential difference between the circumstances in this case and those of a traditional doctor-patient relationship, stating instead that it is rather a matter of degree:

> There is at best only a difference of degree and not of substance in the situation where the patient attends a physician for a third party medical rather than for professional services. In both instances, the patient must disclose personal and private information to allow the physician to make a proper assessment of his/her condition. In addition, the patient may be required to undergo physical examination as well as some tests to assist in such an assessment. In both cases the physician may make certain observations and draw conclusions about the condition of the patient. In rendering a professional service, the physician should make a report directly to the patient about his assessment and may give advice or treatment that the patient is free to follow or not, as they wish. In the third-party medical, a report is not given to the patient but to the insurance company. Such a report may be used by the insurance company in determining matters of entitlement to benefits of the insurance policy to an insured person. The patient may agree or disagree with the insurance company's adjudication. If the insured disagrees and feels her rights under the policy have not been complied with, she may pursue the insurance company for benefits under the policy, which may require an action to be commenced in the courts to enforce such a claim.[176]

The court's second conclusion relates to the nature of a physician's obligation when conducting a medical examination at the request of a third party, which involves acting not only for the benefit of the third person, but for the benefit of the patient as well. In response to Dr. Master's contention that a precondition to a fiduciary relationship identified by McLachlin, J in *Norberg* – the assumption of responsibility for a beneficiary - is missing in the circumstances of this case,[177] Hunter, J held:

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[175] *Supra,* 173 note 173, para. 21

> In my view, this construes the nature of the obligation on the physician who conducts a third party medical too narrowly. Surely, such a physician undertakes the responsibility to complete a proper examination of the patient, draw conclusions from the examination and report the results of the examination and the conclusion. Such examination is for the benefit of the patient as well as the insurance company. The patient is required by the terms of the policy to submit to such an examination at the request of the insurance company. Failure to submit to such an examination may result in a discontinuance of benefits to the insured. The reported conclusion of the physician to the insurance company affects the interest of the insured person. The physician assumes the responsibility to carry out a proper examination and exercises the power over the patient to the extent that the medical report may impact on disability benefits to the patient. In some cases, the physician may even recommend a treatment program, which a patient should undertake in an effort to rehabilitate and become re-employable.[178]

On the strength of the foregoing two conclusions, the court determined that Mrs. Parslow was entitled to see the medical report prepared by Dr. Masters for the insurance company, and Dr. Masters was under a fiduciary obligation to disclose it to her.

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[176] *Ibid.* para. 23.

[177] Great-West contended in para. 25 that,

> at no time did Masters assume or undertake responsibility for Parslow's interests as a patient nor did he expressly or by implication undertake to exercise any power over Parslow for her benefit or to assume responsibility for her interests. The assessment was completed for the benefit of Great-West.

[178] *Ibid.* para. 126.

5. *Law Estate v. Simice*

Most of the discussed above cases emphasize the patient-centered focus of the doctors' duties. A prime example of this is *Law Estate v. Simice*,[179] in which a doctor chose not to provide treatment to her patient because of cost containment constraints imposed by the provincial insurance scheme on the use of such treatment. The court in this case acknowledged the pressure on physicians of budgetary constraints confronting the health care system. But in rendering its final decision, it nevertheless concluded that "these constraints worked against the patient's interests by inhibiting the doctors in their judgment of what should be done for him," and should therefore be "deplored".[180] It went on to state that:

> [I]f it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence in case such as this. The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedure only shows the patient is not suffering from a serious medical condition.[181]

The significance of this decision lies in the fact that the court's rejection of "economic defense" suggests that claims of physician-researchers that they withheld treatment or otherwise failed to act in the best interests of research subjects because of constraints imposed on them by research protocols or contracts with research sponsors, will likely also be rejected.[182]

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[179] (1994), 21 C.C.L.T. (2d) 228 (B.C.S.C.), aff'd [1996] 4 W.W.R. 672 (C.A.)

[180] *Ibid.* at 240.

[181] *Ibid.*

6. Summary

Case law to date has,

1. recognized that a relationship between a physician-researcher and research subject can give rise to fiduciary obligations; the same may be true when the subject is a healthy volunteer,
2. held that the existence of a fiduciary relationship between physician-researchers and patient-subjects is based on the existence of a doctor-patient relationship,
3. imposed a duty on physician-researchers conducting non-therapeutic research to conform to the standard of care expected of a clinical practitioner,
4. imposed on a physician-researcher a duty of full and frank disclosure of all material information,

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[182] In a stark contrast to this Canadian decision, a unanimous Supreme Court in the recent US case of *Pegram v. Herdrich* [530 U.S. 211 (2000)] held that treatment decisions made by an HMO, acting through its physician, are not fiduciary acts under ERISA. At its core, the case asks a question: Does the common HMO practice of providing financial rewards for doctors who reduce utilization of medical services violate ERISA's fiduciary rule? In other words, is the use of financial incentives for HMO doctors to ration care per se illegal under ERISA? The court said no, because decisions that combined questions of eligibility for coverage and treatment judgments, which are so called, "mixed decisions", are not fiduciary acts under ERISA . For the discussion of fiduciary law in this case, see P.C. Borzi, "*Pegram v. Herdrich*: A Victory for HMOs or the Beginning of the End for ERISA Preemption?" (2001) Yale J. Health P'y L & Ethics, 161; N.S. Jecker, "Divided Loyalties: Caring for Individuals and Populations", (2001) Yale J. Health P'y L & Ethics, 177.

5. imposed a duty on physician-researchers to protect the safety and well-being of research subjects throughout a clinical trial, as well as to screen prospective research participants for conditions that prevent them from participating in a research project, and
6. upheld the priority of patient interests in circumstances where physicians hold multiple responsibilities.

III. FIDUCIARY OBLIGATIONS OF PHYSICIANS IN CLINICAL TRIALS

As discussed in Part II, it is well established in law that physicians owe their patients a fiduciary obligation to act with utmost faith and loyalty in all issues regarding patient care. However, given that fiduciary duties are established on a case-by-case basis,[183] this obligation, considered in the context of clinical research, which differs significantly from ordinary clinical care, begs a number of important questions. Do physicians have the same obligation to their patients in the context of clinical trials? If so, does this obligation extend to other research subjects, and to healthy volunteers?

The most appropriate way of deciding whether a researcher-subject relationship is fiduciary involves examining its nature and specific circumstances to determine whether subjects are entitled to expect that researchers will act in their best interests. For this purpose, criteria enunciated by the Supreme Court of Canada for identifying a fiduciary relationship, including the three indicia of Wilson, J's “rough and ready” test, as well as the factors of undertaking, reasonable expectation and trust, will be applied to the various instances of this relationship. Before doing so however, it is important to note that fiduciary duties of physicians flow from the unique nature of their relationship with patients, commonly referred to as a doctor-patient relationship and characterized, among other things, by personal care, trust and confidence.[184] Therefore, as a first step to determining whether the relationship between a physician and a patient in a RCT is fiduciary, one needs to consider whether it can be properly characterized as a doctor-patient relationship.

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[183] For a discussion on situation specificity of the fiduciary relationship, see above, Part II. D.

A. Doctor-Patient Relationship in the Context of Clinical Research

One can argue that the relationship of physician-researchers and research subjects is inherently not a doctor-patient relationship because the delivery of personal care -- one of the essential elements of a doctor-patient relationship -- is neither present nor feasible in the context of clinical research.[185] This may be true in Phases I and II of randomized controlled trials, which are not directed towards treatment, do not guarantee therapeutic benefit for patients, and in this sense, do not encourage an expectation of personal care. Indeed, objectives of clinical care and clinical research, as well as the underlying aims of physicians caring for patients and researchers advancing knowledge for the benefit of the society are completely different.

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[184] On the nature of a doctor-patient relationship and its transformation during the last decades, see *Bioethics in Canada*, supra, note 13 at 109-124, D.J. Rothman, *Strangers at the Bedside: History of How Law and Bioethics Transformed Medical Decision Making* (Basic Books: 1991) [hereinafter *Rothman*], R. M. Veatch, *The Patient-Physician Relation: The Patient as Partner, Part 2*, (Indiana University Press, 1991). See also M.L. Howard, "Physician-Patient Relationship" in Legal Medicine, 4th ed., (American College of Legal Medicine, 1988) 247.

[185] M. S. Frankel, *The Public Health Service Guidelines Governing Research Involving Human Subjects,* George Washington University Program of Public Studies in Science and Technology Monograph no. 10 (Washington, D.C.: 1972) contains evidence that already in mid-60th the NIH policies came to recognize that clinical research "departs from the conventional patient-physician relationship, where the patient's good has been substituted for by the need to develop new knowledge, that the physician is no longer in the same relationship that he is in the conventional medical setting and indeed may not be in a position to develop a purely or a wholly objective assessment of the moral nature or the ethical nature of the act which he proposes to perform" as quoted in *Rothman, ibid,* at 89.

Even those supporting the view that RCT are ethically entirely appropriate, admit that RCTs may violate the "personal care principles". See *e.g., Piantadosi*, supra, note 36.

It has been therefore further argued that a doctor-patient relationship is not an appropriate model for a researcher-subject relationship. Rothman captures the essence of this argument when he states:

> A conflict of interest marked the interaction of investigator and subject: what was in the best interests of the one was not in the best interests of the other. The bedrock principle of medical ethics – that the physician acted only to promote the well-being of the patient – did not hold in the laboratory.[186]

Some also argue that it is inappropriate to judge relationships of physicians and patients, as well as the legal and ethical responsibilities of the former in clinical research by the same standard as in clinical care.[187] Their argument presumes that the foregoing reasons justify lowering the standard of physician-researchers' responsibility toward patients and other subjects of clinical research. Proponents of this view often appeal to the concept of patients' individual autonomy, and suggest that patients who consent to participate in randomized controlled trials (provided that their consent is free and informed), should be free to agree to receive treatment under the terms necessitated by the clinical trial procedures, effectively waiving their right for personal care and allowing physicians to "opt out", at least partially, of their responsibilities as doctors.

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[186] *Ibid*. Rothman, at 88-89.This philosophical argument has been underlining the development of the policies governing the relationships of physicians and patients in clinical research since mid-60th.

[187] See e.g., E. Emmanuel & F. Miller, "The Ethics of Placebo-Controlled Trials: A Middle Ground" (2001) 345 N Engl J Med 915; *Miller & Brody, Placebo-Controlled Trials, supra*, note 75.

It follows that the terms of patients' relationship with physicians become redefined in clinical trials in order to account for the requirements of the randomized controlled trial, including for example the fact that physicians, in addition to their responsibilities toward individual patients, assume responsibility towards the research project, its sponsors and other research subjects and, therefore, may be unable to act with the utmost loyalty in the interests of an individual patient-subject. One could further argue therefore that, when patients enter randomized controlled trials, the traditional doctor-patient relationship ends and a new physician-researcher/patient-subject relationship is established which may not be fiduciary in nature.

The foregoing arguments are, however, both legally and ethically questionable. A doctor-patient relationship generally continues to exist as long as physicians have an obligation to treat their patients. It follows that, where an individual patient is under the care of his doctor, any experimentation or research is performed on a care-associated basis, meaning that the essential doctor-patient relationship continues and should be maintained.[188] Although the main purpose of randomized controlled trials is not to treat individual patients, it should nevertheless be presumed that physicians who offer their patients the opportunity to participate in a clinical trial, which tests treatments designed to treat the patients' condition,[189] do so with the intention of benefiting the patients' health. As will be seen later in this paper, most patients who agree to participate in randomized controlled trials also have an expectation of personal benefit.[190]

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[188] *Law and Medical Ethics*, supra, note 84 at 351.

[189] This is likely to happen in Phase III clinical trials where there is a hope to introduce a lasting beneficial change in the patients participating in the study and to prevent or reverse the progression of a disease. See above, part I.B.1.

The foregoing analysis of the relationship between a physician and a patient in a RCT presumes a pre-existing, and in this sense, traditional doctor-patient relationship between them. This, however, refers only to one possible scenario of a physician-researcher/patient-subject relationship. Many clinical trials involve individuals who do not have a history of doctor-patient relationship with physician-researchers, but who nevertheless enter RCTs with a hope or an expectation of a therapeutic benefit. Yet another group of research subjects includes so called “healthy volunteers”, people who participate in research primarily for altruistic reasons or out of a desire to benefit financially. The more difficult, but very important question to address is: do physician-researchers also form a doctor-patient relationship with these research subjects?

The relationship of physician-researchers with individuals who were not their patients prior to entering into a trial, but who nevertheless suffer from the condition investigated in the study and hope to personally benefit from their participation, is a doctor-patient relationship unless those individuals explicitly state otherwise. The main reason for this is that physicians involved in clinical research hold themselves out as doctors and are perceived as such by individuals who enroll in clinical trials as part of their search of better treatment. The same holds true whether sick research subjects are enrolled in therapeutic or non-therapeutic clinical trials. For example, a doctor-patient relationship will likely be found between physician-researchers and individuals afflicted with terminal cancer or HIV AIDS, who enroll in non-therapeutic, high risk Phase I/II trials in a desperate hope for a cure, or at least for relief from their symptoms. The high risk of such experimental procedures will likely intensify the responsibility of physician-researchers toward these patients.

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[190] See below, part III.B.4.

The case-law, including *Halushka* and Weiss, as well as soft law[191] also allow one to argue that physicians-researchers form doctor-patient relationships with healthy volunteers in non-therapeutic research. The reason is that, even in non-therapeutic research, physicians hold themselves out as doctors, who administer drugs or conduct procedures which can affect the health and well being of healthy volunteers. While *Parslow* is not a case involving clinical research, it nonetheless demonstrates that where a physician encounters an individual for purposes other than treatment *per se*, what changes is not the nature of the doctor-patient relationship between them but rather, the degree of the physician's obligation to the patient.[192] *Parslow* seems to reflect a developing trend in the courts to adopt a broad view of the doctor-patient relationship, recognizing that a fiduciary relationship can arise not only in a traditional therapeutic setting, but in other circumstances where physicians interact professionally, regardless of the reason for interaction.[193] Some commentators predict that the same broadening of physicians' legal duty is likely to occur in the context of research.[194]

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[191] See above, part I.C.

[192] See above, n.178 and accompanying text.

[193] This approach also finds support in the body of US case-law, which suggests that a fiduciary relationship may be found even when there is no therapeutic or true doctor-patient relationship, For example, in the case of a physician examining a prospective draftee for military service in *Betesh v. United States,* 400 F. Spp.238 (D.C.D.C. 1974), the court held that there was no

Neither law nor ethical guidelines contain any provisions for physicians to "opt out" or "contract out" of their duty to exercise their judgment and skill in the best interests of those who are in their care.[195] Instead, both policy documents and law consistently state that, in clinical research, physicians should adhere to at least the same standard of care and conduct, and retain the same obligations as they do in ordinary clinical practice.[196] Once a doctor-patient relationship is established, it is difficult for a physician to justify lowering the standard of care expected of himself as a doctor, especially, through reliance on a patient's informed consent to participate in clinical research.[197] Patients' consent to clinical trial participation means that they accept to be treated in a research setting, where there is less certainty about the effect and success of their treatment than in a traditional clinical setting. In fact, the greater risk associated with experimental research justifies the imposition on physicians of greater

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therapeutic relationship between the physician and the draftee, but nevertheless, found that the professional relationship was of fiduciary nature and imposed an obligation of disclosure in the draftee's interests; or in the case of a psychotherapist and a third party who was at risk of serious injury from the patient in the care of the psychotherapist in the famous case of *Tarasoff v. Regents of the University of California*. 551 P.2d 334 (Sup. Ct. Cal. 1976). In the latter case the court held that the fiduciary obligation to make a disclosure to an identifiable third party at the risk of serious injury arose from a special relationship of psychotherapist and a patient. Also see *Pittman Estate v. Bain* (1994), 112 D.L.R.(4d) 257 (Ont. Gen. Div.) concerning failure of the doctor to inform a wife of her husband's HIV infection.

[194] See e.*g*. A.R. Holder, "Do Researchers and Subjects Have a Fiduciary Relationship?" (1982) IRB 6-7 [hereinafter *Holder*].

[195] See K. Glass & T. Leroux, "Legal Perspective" in *Placebo Report*, *supra*, note 50 at 42.

[196] For the overview of the relevant policy provisions, see above, part I.C; for the overview of the relevant case-law see above, part. II.C.2-3.

responsibilities for the health and well being of research subjects. As Henrik Bendixen insightfully observed in his letter to Henry Beecher in 1966[198] regarding the nature of tacit consent patients give by requesting admission into teaching and research hospitals:

> The fact that the patient is requesting admission to this hospital represents tacit consent. How do we interpret tacit consent? Not as a license but as a trust. This adds, not subtracts, responsibility.[199]

It is true that some patients are prepared to sacrifice an element of personal gain to help others, provided they are fully informed about the risks and benefits of the treatment and other terms of their participation. However, altruism is a personal prerogative and should never be presumed on behalf of research subjects when obtaining their consent to research.[200] Those who design and conduct clinical trials, as well as policy-makers, should err on the side of caution, proceeding on the presumption that prospective research subjects who suffer from a medical condition under investigation, enter the clinical trial with an expectation of benefiting personally. Any presumption to the contrary could dangerously steer research and its ethics astray.[201]

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[197] See *Holder, supra*, note 194.

[198] Henrik Bendixen to Henry Beecher, March 1966, Henry Beecher Manuscripts, Francis A. Countway Library of Medicine, Harvard University as cited by *Rothman, supra*, note 184 at 91.

[199] *Ibid*.

[200] In fact, studies that examined views of research subjects have shown that even those patients who described themselves as sincerely motivated to help others, in a further discussions suggested that they would not have participated if they did not believe that some personal benefit might result as well, see e.g., *Kass, Trust, infra,* note 219

[201] See *Beecher, Research & Individual, supra*, note 6

Based on the foregoing, it is clear that the relationship of physicians with their patients, and likely other research subjects, is properly described as doctor-patient. The fact that physicians undertake to conduct research on their patients does not constitute a legitimate reason for reducing the standard of care that they should meet. In fact, being a researcher adds obligations to those existing already by creating a heightened standard of care. These conclusions provide an initial basis for concluding that physician-researchers owe their patients and possibly other research subjects a fiduciary obligation. The application of Wilson J's "rough and ready" test and other criteria commonly used by Canadian courts for identifying a fiduciary relationship further support this conclusion.

B. Wilson J's "Rough and Ready" Test and Other Criteria for Identifying a Fiduciary Relationship

As previously noted, Wilson, J's "rough and ready" test proposes three main indicia for identifying a fiduciary relationship: (a) the relationship includes the scope for the exercise of some discretion or power by a fiduciary; (b) the purported fiduciary can exercise that power or discretion unilaterally so as to affect the beneficiary's legal or practical interests; and (c) the beneficiary is peculiarly vulnerable to the exercise of that discretion or power. Other factors used by the Supreme Court of Canada in determining whether a fiduciary relationship exists include trust, undertaking by the fiduciary to act in the best interests of the beneficiary and a corresponding expectation on the part of the beneficiary[202]. Each criterion will be applied in turn in the context of physician-researchers' relationships with patients and healthy volunteers.

1. Power Imbalance Between Positions of Physicians-Researchers and Research Subjects

The relationship of physicians and research subjects in clinical trials is clearly characterized by power imbalance, especially in cases where research subjects are ill individuals. This imbalance is perhaps greater than in a traditional therapeutic setting. While in a therapeutic relationship physicians hold a position of trust and power by virtue of their expertise, knowledge of patients' health and other personal and private information,[203] in a clinical trial, their status as scientists and a more comprehensive and up-to-date knowledge of diseases as well as access to the latest and potentially most promising treatments further raises their authority in the research subjects' eyes. All these combined, allow physician-researchers to influence or affect many aspects of research subjects' involvement in clinical trials: they decide whether or not to enroll research subjects in clinical trials and determine an acceptable level of research risk for them, which is essential in deciding when to stop a trial or to withdraw a particular research subject from it. The complexity of medical and

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[202] See above, n. 115.

[203] See *Law & Medical Ethics*, *supra*, note 84 at 3:

> Just as the lawyer knows more about the law than does his client, so the doctor knows more about medicine than does his patient. The patient's attitude, therefore, is poised between trust in the learning of another and the general distrust of one who is in a state of uncertainty. Such ambivalence leads

scientific information, together with its highly speculative nature further magnifies the power imbalance between physician-researchers and research subjects in clinical trials.[204]

2. Physician-Researchers' Ability to Exercise Power and Discretion Unilaterally

The question that should be asked in applying this indicia is: can physician-researchers exercise their power or discretion unilaterally, that is, without the consent of research subjects? Despite a number of factors that moderate the impact of physician-researchers' decision-making authority, such as the informed consent requirement and REB review, physician-researchers, as main decision-makers in clinical trials, nonetheless have numerous opportunities to exercise their power and discretion unilaterally.

The requirement of free and informed consent has given material expression to the idea of research subjects' autonomy with a view to making them partners with physician-researchers in the decision-making process about their treatment. The *TCPS,* for instance, explicitly states that research projects conducted under the auspices of this policy may begin only if,

> prospective subjects, or authorized third parties, have been given an opportunity to give free and informed consent about participation, and (2) their free and informed consent has been given and maintained throughout their participation in the research.[205]

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naturally to a sense of inferiority: [it is the function of medical ethics to ensure that the potential superiority of the doctor is not abused.

[204] See *Banks, supra,* note 149 at 575.

[205] *TCPS, supra*, note 4 Section 2, A, 2.1 (a).

It is also recognized that because of the generally higher educational level and the greater availability of medical information through media and the Internet, patients who enter clinical trials today are on average better informed and able to understand their medical condition and the terms of their participation in clinical research than once was the case.

It is important to note that the requirement of full disclosure is much more explicit in research than it is in clinical care[206] and has virtually no exceptions.[207]

The discretion of physician-researchers in clinical research is also restricted to a certain extent by local REB reviews which protect the interests of research subjects by ensuring that the research intentions of the physician-researchers, as expressed in a trial protocol and other related documentation, are scientifically sound and ethically permissible.[208]

Notwithstanding the foregoing, neither the power of informed consent, nor the authority of an REB review in restricting the discretion and decision-making power of physicians-researchers should be overestimated. First, the idea of complete disclosure in research, while a necessary and worthy objective, is hardly ever attainable in practice, and as a result, informed consent is often given on the basis of incomplete information and in the face of inherent uncertainty that attends any experimental research. This means that in some cases subjects' consent should be viewed as an expression of their trust that physician-researchers will protect their interests, especially when they are unable to do so themselves, rather than their agreement to assume full responsibility for their health and safety in a clinical trial. Second, apart from initial approval and periodical review, REBs have limited means to closely monitor the propriety of physician-researchers' day-to-day decisions.[209] Third, the fact that physicians combine patient care with clinical research, and become thereby the main decision-makers in clinical trials and patients' principle and often sole advisors on issues of both treatment and participation in research, reinforces their decision-making authority. For example, physician-researchers have extensive control over information they collect about their research subjects and have many opportunities to decide how to use and disseminate it. By exercising this power physicians can affect subjects' legal and practical interests. For example, withholding from a patient-subject information about a misdiagnosis that came to light in the course of a clinical trial could adversely affect his health and therefore be actionable in negligence.[210] There are,

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[206] For example, the subjects' initial consent for research is normally obtained in writing; an informed consent form is approved by an REB and contains a wider range of information, including sources of funding, those who will have access to the personal information of subjects, anticipated uses of data, see e.g., *Helsinki Declaration, supra,* note 43 article 22, which reads:

> In any research on human beings, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail.

See also *TCPS, supra* note 19 section 2 D, Article 2.4 and Table1.

[207] See *Halushka, supra*, note 159 at 444. The same idea is echoed in academic publications, see generally *Picard & Robertson, supra,* note 64 at 87.
It should be noted that, although, that *TCPS* allows REBs to waive the requirement of informed consent or to alter some or all of its elements in a number of specified conditions, see Section 2, Art. 2.1(c), these provisions would, however, most likely apply to the research in social studies or psychology, rather than to clinical research.

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[208] Major changes to the study design and procedures are also subject to a REB approval, see *TCPS, ibid.* Section 1 A, B.

[209] *Ibid.* Section 1, F. article 1.13.

[210] *Banks, supra,* note 149 at 577.

however, many other ways for physician-researchers to unilaterally exercise their discretion in relation to the subjects' care and participation in research.

3. Peculiarly Vulnerability of Patients-Subjects

It is not difficult to demonstrate that research subjects are vulnerable to abuse or misuse of power and discretion by researchers. The history of medical experimentation is replete with examples of research subjects who have been exploited by medical researchers.[211] Vulnerability of research subjects is also clearly implied by the protection inherent in international and national policy documents. Although the effect of researchers' influence on subjects may be significantly mitigated by the informed consent requirement, the potential for undue influence remains a serious issue. Cases of exploitation are perhaps the starkest and therefore, the most obvious examples of the power-imbalance between physician-researchers and research subjects and the vulnerability of the latter in clinical research. It is, however, important to point out that even in a relationship where the physician-researcher has no obvious intention to exploit the research subject, their relative positions in the clinical trial are such that they create a potential for the physician-researcher to violate the rights of the research subject.

The degree of a subject's vulnerability in a clinical trial will vary depending on several factors such as, for example, the severity of his health condition, his general education and how well he is informed about his condition and available treatment for it, other support available to him, his previous relationship with the physician, his general mental state and so on. But there are also factors specific to clinical research that increase the vulnerability of any research subject. The nature of the patient's vulnerability in research is different than in the ordinary clinical setting. As previously mentioned, in research patients-subjects are exposed to a general uncertainty about the outcome of experimental research, and often to a greater probability and magnitude of possible harm than they would in a normal therapeutic setting. This is captured by the notion of so called, "minimal risk".[212] Other factors also contribute to their vulnerability. First, by entering a clinical trial patients often accept treatment in conditions which are not tailored to their individual needs. Second, they often have to disclose a lot of personal information, as well as cope with information about themselves and their families that may be discovered in the course of research. Third, many seriously ill patients, including those with rare or untreatable medical conditions turn to clinical trials, after having exhausted standard treatments' which provided little or no benefits. They often view an experimental treatment as their last hope to relieve their pain and suffering, or possibly save their lives. These patients are effectively "at the mercy" of physician-researchers leading clinical trials. They place an immense trust in physician-researchers to guide them though decisions about their participation in clinical trials. Finally, certain elements of clinical trial design such as, for example, randomization and blinding techniques that require keeping the treatment secret from subjects, render them even more vulnerable and make them trust and rely on physician-researchers to protect their interests.

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[211] See *supra*, n. 7

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[212] Analysis, balance and distribution of harms and benefits in research is commonly described by employing the standard of minimal risk, which defined by the TCPS as follows: "if potential subjects can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research than the research can be regarded as within the range of minimal risk". Many clinical trials involve risk that is above the threshold of minimal which "warrants a higher degree of scrutiny and greater provision for the protection of the interests of prospective subjects." see *TCPS*, *supra*, note 4 C1 at 1.5.

4. Trust

Trust in the relationship between professionals and those who they advise or whose interests they serve is commonly understood as an expectation by the latter that the former can and will act in their interests and meet their professional responsibilities to them.[213] Trust has many aspects. In relationships with physicians, it normally includes: (1) an expectation about physicians' competence, (2) reliance on physicians' agency, (3) physicians' control over decision making, and (4) reliance on confidentiality and disclosure.[214] All the foregoing aspects of trust are present in the relationship of physicians and research subjects in clinical trials.

Today's public expectation of physicians' competence in clinical research is beyond question. The fact that clinical trials are conducted in hospitals, research centers and by licensed physicians in private clinics, as well as authorized by Health Canada and thoroughly reviewed by REBs, effectively means that they cannot be conducted by unqualified individuals, as sometimes happened in the past. The *Helsinki Declaration* states to this effect that:

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[213] See D. Mechanic, "The Functions and Limitations of Trust in the Provision of Medical Care" (1998) 23:4 J. Health Politics, Policy & Law 661, at 662 [hereinafter *Mechanic*].

[214] *Ibid.* at 668.

> Medical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person.[215]

Physician-researchers hold themselves out, and are naturally perceived, as having in-depth, cutting edge and sometimes exclusive knowledge in their field of study. Research subjects expect that research procedures in clinical trials will be performed with the skill and diligence normally expected of physicians. Since competence includes more than knowledge, technical skills and judgment, patient-subjects also expect that physician-researchers will have good interpersonal skills to help them feel at ease in the face of uncertainty and potential risk of the experimental treatment, and will be attentive and considerate of their concerns and preferences.[216]

Patient-subjects further expect that physicians will act as their agents and not simply as neutral decision makers.[217] This expectation is particularly strong in seriously ill and therefore, highly dependent patient-subjects.[218] In high-risk experimental procedures, the informed consent of desperately sick people is a clear expression of trust. Patient-subjects' belief that physician-researchers will act in their best interests persists despite signals to the contrary communicated to them through the informed consent procedure and physicians' disclosure of conflicts of interest.

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[215] *Helsinki Declaration, supra*, note 43 B15.

[216] See *Mechanic, supra*, note 213 at 665.

[217] *Ibid.* at 668.

[218] *Ibid. at* 667.

It is widely assumed that informing prospective subjects about the risks and possible benefits of research not only protects their rights as autonomous decision-makers, but also empowers them to protect their own interests. However, a number of studies analyzing patient-subjects' experiences in and attitudes toward research, including the *Subject Interview Study* conducted under the auspices of the Advisory Committee on Human Radiation Experiments, found that this is often not the case.[219] Patient-subjects significantly rely on their physicians to guide and advise them on various issues concerning their participation in research, as well as to protect their interests. Patient-subjects' expectations about clinical trials and physicians' role in them are shaped to a great extent by their perception of the traditional doctor-patient relationship and as such, are influenced by the immense trust they place in the advice of physicians.[220] As Goldner rightfully noted,

> [t]he fact that the patient's trust in his physician is a crucial factor in the patient's willingness to participate in a clinical study cannot be refuted.[221]

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[219] N.E. Kass, *et al.*, "Trust: The Fragile Foundation of Contemporary Biomedical Research," (1996) 26:5 Hastings Center Report 25, at 25 [hereinafter *Kass, Trust*]. This article describes in-depth interviews of about 100 out of 1,900 patients enrolled in the *Subject Interview Study*, a project designed to examine their experience and attitudes about research. Detailed description of this study can be found in Chapter 16 of the *Final Report of the Advisory Committee on Human Radiation Experiments* (Washington, D.C.: U.S. Government Printing Office, 1995), at 724-57; see also *Lidz, Therapeutic Misconception, supra*, note 59.

[220] Studies indicate that patients also place significant trust in the hospitals they receive their care in and in the integrity of the research enterprise as a whole, *ibid*, at 26.

A couple of typical responses from the Subject Interview Study illustrate the point:

> My personal reasons [for enrolling] were because I was advised to do it (335227-5)
>
> He asked me if I wanted to go on it, and I said' 'If it's what you think I should do, yes, because you know more about it than I do.' ... [H]e said, 'I think it would be a good idea to try it'" (552264-4).[222]

As the result, the authors of the study concluded, among other things, that:

> Clinicians should be mindful of the tremendous influence they have over their patients, given that the mere suggestion of enrollment in research by a patient's personal physician was interpreted by many patients to be an endorsement.[223]

The findings of the study also led its authors to believe that patients' trust "seems to hinder the adequate fulfillment of the informed consent process" and to suggest that:

> the current emphasis in research ethics on analyses of benefits and risks and on subjects' autonomous decision-making is insufficient. The paradigm must be enriched with a sensitivity to the profound trust participants place in researchers and the research enterprise.[224]

Recognizing this fact, the Helsinki Declaration stipulates that,

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[221] J.A. Goldner, "Dealing with Conflicts of Interest in Biomedical Research: IRB Oversight as the Next Best Solution to the Abolitionist Approach" (2000) 28 J.L. Med. & Ethics 379 at 382.

[222] *Kass, Trust, supra*, note 219 at 26.

[223] *Ibid*. at 28.

[224] *Ibid*. at 26-27.

> The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given consent.[225]

Individuals who agree to participate in clinical trials generally believe that physician-researchers have the necessary discretion to protect their interests in clinical trials and are able to exercise it on their behalf. However, the trust of patient-subjects may diminish if they realize that research protocols and obligations to third parties may significantly limit physician-researchers' discretion.[226]

Patient-subjects also assume that, as in a traditional therapeutic relationship, information they communicate to physician-researchers in the course of a clinical trial will be kept confidential and not shared with others without their expressed permission. However, patient-subjects' reliance on confidentiality may be undermined by certain research practices that require physician-researchers to share subjects' information for secondary research use. Sharing subjects' information among multiple clinical trial sites and creation of large genetic databases are but two examples of such practices. In this context, subjects' consent to future uses of their personal information, when one cannot anticipate the exact purposes for which this information may be used, is also an expression of subjects' trust.

Strict enforcement of the informed consent procedure also creates an expectation on the part of patient-subjects that physician-researchers will share with them information they need in order to make informed decisions about their participation in a clinical trial. However, patient-subjects' trust in this regard could diminish if they realize that such information may be withheld by physician-researchers if, for example, it is so required by the clinical trial design or in order to conceal a physician-researcher's conflict of interest.

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[225] See *Helsinki Declaration, supra,* note 43 B15.

[226] See e.g., *Lidz, Therapeutic Misconception, supra,* note 59.

It is clear from the foregoing that every aspect of trust present in a traditional therapeutic relationship is also present, perhaps sometimes with even greater intensity, in a physician-researcher/patient-subject relationship. Evidence of trust provides crucial support for concluding that physician-researchers owe their patients and other research subjects a fiduciary obligation. Such evidence meets the ultimate test for recognizing the existence of a fiduciary relationship:

> The likelihood that a researcher would be found to be a fiduciary would depend not only on the specifics of the relationship, but may also depend on the willingness of a court to infer that the relationship of researcher-subject was as much built on trust as that of the doctor-patient relationship.[227]

However, a cautionary note is in order. No matter the strength of patient-subjects' trust in physician-researchers, one should ask which of patients-subjects' expectations are reasonable and legitimate and whether the trust they repose in physicians-researchers is not misplaced.

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[227] A. Côté, "Adequate Protection for the Autonomous Research Subject? The Disclosure of Sources of Funding and Commercialisation in Genetic Research Trials" (2002) 28 Man. L.J. 347 [online: QL] [hereinafter *Côté*] para. 37.

5. Undertaking and Reasonable Expectations

The foregoing analysis of physician-patient relationship in clinical trials, as well as a review of sample consent forms of the several Canadian hospitals and research centers,[228] suggests that the scope of physician-researchers' actual undertaking vis-à-vis patient-subjects in clinical trials is considerably less than what is normally expected of a physician-fiduciary. For example, in a trial that uses placebos and randomization technique for assigning subjects to its different arms, physician-researchers cannot undertake to administer treatment to patient-subjects based solely on their individual therapeutic needs, and in this sense, act in their best interests. Similarly, in clinical trials, which are increasingly conducted by teams of researchers where functions and responsibilities are delegated to its members, physicians cannot practically assume sole responsibility for the health and well-being of the individual patients.

It is obvious therefore that in clinical trials, physicians do not undertake the full scope of responsibilities expected of them as fiduciaries because, as clinical researchers, they also have explicit responsibilities to the research projects and other players in them, which are not in line or openly conflict with their fiduciary obligation to act in the best interests of individual patients-subjects. The expectations of patients-subjects are also equivocal: on the one hand, based on the trust and reliance inherent in a traditional doctor-patient relationship, while on the other hand, informed by the terms and conditions of their participation in a trial[229].

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[228] Author's personal copies.

The factors of undertaking and reasonable expectation therefore do not clearly point towards the existence of a fiduciary relationship between physician-researchers and patient-subjects. Instead, considered in context, these factors reveal that there may be significant discrepancies between what is legally and ethically required of physicians-researchers and their actual undertaking. The fact that physician-researchers seem to assume reduced responsibilities vis-à-vis their patients in clinical trials, and that patient-subjects sign consent forms that often do not match their real expectations highlight problems in current practices of enrolling patients in RCTs, which from a legal and ethical standpoint may be questionable at best and impermissible at worst.

6. Summary

The forgoing analysis of the physician-researcher/patient-subject relationship demonstrates that all factors that point to the existence of a fiduciary relationship – power imbalance, ability by a physician-researcher to exercise this power unilaterally, pecuniary vulnerability of the patient-subject, as well as trust -- are present in the circumstances of this relationship. The intensity of these factors will, however, vary significantly depending on the particular circumstances of the relationship. Thus, for example, the likelihood of physician-researchers owing patient-subjects a fiduciary obligation is greater in the therapeutic phase of a clinical trial if research subjects are desperately ill and have been led to believe that the experimental treatment has a real prospect of helping them. In contrast, the chances of fiduciary obligations being found is significantly smaller in cases of healthy, well-informed volunteers who participate in a clinical trial whose scope does not require extensive disclosure of personal information and does not involve significant risk. However, the application of the factor of undertaking arguably suggests that, in RCTs, physicians are either prevented from or choose not to undertake the full scope of their fiduciary obligation toward patient-subjects.

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[229] It is interesting to note in this regard that a standard informed consent form does not normally describe the role or personal responsibility of the physician-researcher for the health, well-being or treatment of the patient-subjects, effectively leaving it for the latter to guess what kind of relationship they will have with physicians in a clinical and what they should and should not expect from them in terms of advice, support or protection.

Taken together, nevertheless, the foregoing factors weigh heavily in favor of the view that a physician-researchers owe a fiduciary obligation to patients and other research subjects in clinical trials.

C. Ideals of Fiduciary Law Versus Cannons of Randomized Controlled Trials: Is a Meaningful Co-Existence Possible?

Having established, at least for the purposes of this paper, that physician-researchers owe a fiduciary obligation to their patients, and in some cases to healthy volunteers, it is necessary to consider how fiduciary law principles apply in the context of clinical trials, what impact they have on the relationship between physician-researchers and research subjects and their respective responsibilities and entitlements. The following discussion will therefore describe factors that impede on the one hand, and compel on the other hand, the application of the fiduciary law standard to the conduct of physicians in clinical trials.

Even those who claim that a well-designed and conducted RCT "is an ethically appropriate way to acquire new knowledge", admit nevertheless that "these studies highlight important concerns and create the potential to violate the rights of research subjects."[230] While not suggesting that RCTs are inherently unethical, as presently designed and conducted they nonetheless seriously challenge the ability of physicians who combine patient care with research to fulfill their fiduciary obligation to patient-subjects and to adequately protect their interests. This is mainly due to the intensity of the conflict between their duties as treating physicians and clinical investigators. Certain arrangements in clinical trials, mostly those with commercial sponsors, also have a real potential for influencing physician-researchers' discretion and challenging their ability to protect the interests of patients-subjects. Ultimately, the question that has to be asked is whether, given the nature and intensity of those conflicts, fiduciary law can tolerate them and if not, whether the activities leading to them should be discouraged or prohibited.

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[230] See *Piantadosi, supra,* note 36 at 34.

1. Challenges Posed by the Concept and Design of RCTs

Certain elements of RCTs' design may undermine physician-researchers' ability to act in the best interests of research subjects. Despite wide acceptance of the need for a subject-centered perspective in research involving humans, and the fact that some phases of RCTs are regarded as therapeutic, the reality is that they are generally not designed with the subjects' interests in mind.[231] In such circumstances, the role of physician-researchers and their freedom to exercise their discretion becomes of paramount importance, essentially serving as the main guarantee of the research subjects' safety in trials.[232] However, the design of an RCT often discourages physician-researchers from exercising their professional judgment as doctors or simply takes away their power to make decisions, thereby undermining their ability to protect the interests of research subjects. For example, an experimental treatment is often assigned to patient-subjects randomly rather than prescribed by a physician according to their individual needs. Moreover, through the use of placebos, some patients in clinical trials are left untreated.[233] Similarly, during the trial, physicians cannot adjust the dose of the treatment according to the needs of individual patients, or change other conditions of how it is administered.

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[231] See *Bioethics in Canada, supra*, note 13 at 315

[232] According to Beecher, two main safeguards for patients in research process are their free and informed consent and "intelligent, informed, conscientious, compassionate, responsible investigators." See H.K. Beecher, "Ethics and Clinical Research" (1966) 274 N Engl J Med 1354, at 1360. Along the same lines, Beauchamp and Childress have also held that "the researcher-physician's commitment to the welfare of his or her patients offers the best protection." See T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics*, 2nd ed., (Oxford University Press, 1983) [hereinafter *Beauchamp & Childress*] at 247.

[233] The extreme position is that "placebos offend fundamental rightness of fidelity", see B. Simmons, "Problems in Deceptive Medical Procedures: An Ethical and Legal Analysis of the

Fiduciary law's response to situations where physicians lose their power to make decisions regarding aspects of their patients' care is fairly clear. First, its general principles require the undivided loyalty of physician-fiduciaries' to the interests of their patients. Second, it requires decisions about beneficiaries' interests to be made by physician-fiduciaries themselves. They cannot yield their personal responsibility for the well-being of beneficiaries by delegating their duties to others.[234]

However, physician-researchers involved in clinical trials are not always able to meet these fiduciary law requirements. Possible solutions, particularly in cases where there is a significant concern that physician-researchers may not be able to act in the best interests of patient-subjects, include either requiring physicians not to enroll patients in their care in RCTs conducted by them, or allowing physicians to do so only if patients' primary care is entrusted to another physician.[235] The main objective of dissociating primary care and clinical research responsibilities of physicians is to ensure that patients who participate

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Administration of Placebos" (1978) 4 J Med Ethics 172 as referred to in *Law & Medical Ethics*, supra, note 84 at 358.

[234] See also M. Litman & L. Sheremeta, "The Report of the Committee of Inquiry on the Case Involving Dr. Nancy Olivieri: A Fiduciary Law Perspective" (2002) 10:2 Health L. Rev. 3 [hereinafter *Litman & Sheremeta*]

[235] Similar suggestions have been discussed previously. Beuachamp and Childress for example, expressed a view that a person should not assume the role of an investigator and a clinician for the same patient-subject, similar to the view that the physician who is to transplant a kidney from A to B should not be allowed to determine when A is dead. See *Beuachamp & Childress, supra,* note 232, at 247.

in RCTs are not deprived of the essential benefit of personal care and independent advice of their physicians, while at the same time saving physician-researchers from having to deal with inevitable conflicts of interest or those which may be beyond their ability to manage.

The foregoing suggestions should not be understood as implying that it is inherently unethical for physicians to conduct RCTs on patients in their care. In fact, in some situations the most ethical thing for a physician to do is to enroll his patient into a trial conducted by him. Consider for example a case where the physician is the only practitioner in the country studying a new, promising treatment for a rare medical condition suffered by his patient.

Whatever solution is reached to the problem of divided loyalties, it should alert physicians, research institutions and REBs to the fact that cases where physicians conduct RCTs on patients in their care raise great concerns about the protection of patient-subjects' interests and the integrity of the research project. REBs should pay particular attention to such cases and be aware of the required legal and ethical standards against which to gauge physicians' conduct in them.

2. Challenges Posed by Financial Incentives and Contractual Agreements in Clinical Trials

It is not only the design of the RCTs, but also arrangements among researchers, institutions, sponsors and research subjects, which accommodate research in a clinical setting, that often make the performance by physician-researchers of their fiduciary duties difficult, if not altogether impossible. The range of such arrangements is broad and may include contracts, institutional policies and other documents, written or spoken agreements and various financial or administrative practices which, by virtue of imposing on physician-researchers certain requirements, conditions or expectations, undermine their role as a prime care-givers and as fiduciaries. For the purpose of this paper, only a few examples of these arrangements, namely, financial incentives and contractual clauses will be considered.

a) Per Patient and Finder's Fees

With the dramatic rise of private sector support for biomedical research in Canada and United States,[236] the financial relationships between physician-researchers and research sponsors have increasingly became the subject of public attention and academic scrutiny.[237] Put simply, the prime concern surrounding financial arrangements in clinical trials is the potential influence of money on the research process.[238] The fact that clinical trials are paid for by commercial sponsors creates a significant potential for a conflict of interest for physician-researchers.[239]

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[236] See D. Blumenthal, et al., "Relationships Between Academic Institutions and Industry in the Life Sciences – An Industry Survey" (1996) 334: 6 N Engl.J Med 368; A. Silversides, "Private Sector Becoming the Key to Research Funding In Canada" (1998) 159 CMAJ 397.

[237] See e.g., J. P. Kassirer & M. Angell "Financial Conflicts of Interest in Biomedical Research" (1993) 329 N Engl J Med 570; G. Guyatt, "Academic Medicine and the Pharmaceutical Industry: a Cautionary Tale (1994) 150:6 CMAJ 951; W.W. Arkinstall, "Interaction Between Physicians and the Pharmaceutical Industry [letter] (1995) 153:4 CMAJ 398.

[238] Empirical studies have shown a clear association between the source of funding and the outcome of research studies. See *e.g.,* J. Lexchin, "Interactions Between Physicians and the Pharmaceutical Industry: What Does the Literature Say?" (1993) 149:10 CMAJ 1401; R.A. Davidson, "Source of Funding and Outcome of Clinical Trials" (1986) 1 J Gen Intern Med 155 (this study examined over 100 clinical trials and found that those of them funded by pharmaceutical companies were less likely to conclude that traditional therapy is better than a new experimental drug); E.G. Campbell, K.S. Louis, D. Blumenthal, "Looking a Gift Horse in the Mouth: Corporate Gifts Supporting Life Sciences Research" (1998) 279:13 JAMA 995.

Pharmaceutical companies actively attempt to influence decisions physicians make in their clinical practice and research by offering them various financial and other incentives.[240] The most common financial incentives[241] involve researchers receiving per-patient and finder's fees, gifts from commercial sponsors, as well as having equity interests in a sponsor's company.[242] The consequences of such conflicts of interests are well-recognized and include erosion of the doctor-patient relationship, undermining of the integrity of both, research and patient care, as well as of the public trust in the whole research enterprise.[243] This conflict, which arises in most, if not all commercially sponsored clinical trials, is difficult to avoid because of the need to transfer scientific discoveries into useful, commercially viable medical products. It should be expected therefore that relationships between industry and physicians will likely only grow stronger in the future. It is important to note that there is nothing inherently unethical about interactions between physician and industry. In fact, the research community relies significantly on private sector support to facilitate research progress. However, an issue that requires serious consideration by academics, the medical profession, industry and government sponsors of research is: what are the appropriate principles for governing these relationships? The way financial incentives interfere with physicians' performance of their fiduciary duties and how they should be dealt with from the standpoint of fiduciary law can be illustrated by considering the role and effect of per-patient and finder's fees.

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[239] A conflict of interest is commonly defined as "a situation in which professional judgment regarding a primary interest, such as research, education or patient care, may be unduly influenced by a secondary interest, such as financial gain or personal prestige" See T. Lemmens & P. Singer, "Bioethics for Clinicians: 17. Conflict of Interest in Research, Education and Patient Care" 159 JAMC 960 [hereinafter *Lemmens & Singer*] at 960.

[240] See especially J.E Bekelman, et al. "Scope and Impact of Financial Conflicts of Interest in Biomedical Research. A Systematic Review", (2003) 289:4 JAMA 454; P. Komesaroff, "Doctors' Interactions with the Pharmaceutical Industry: Science or Commerce?" [editorial] (2001) 31 Intern Med J 446 [hereinafter *Komesaroff*]. The scale of their investment in such activities is very significant, see S.M. Wolfe, "Why do American Drug Companies Spend More Than $ 12 Billion a Year Pushing Drugs? Is it Education or Promotion?" (1996) 11 J Gen Intern Med 637. Also see CBC, "Ideas", "Manufacturing Patients" September 2003; CanWest Series "Drug, Money & Ethics" *National Post,* February 23-28, 2004 [hereinafter *Drugs, Money & Ethics*].

[241] Financial interests are not the only, or necessarily the most powerful secondary interests for investigators. Other pressures, including the desire for professional recognition and the need to compete successfully for research funding, are intrinsic to the research process, see N. Levinsky, "Nonfinancial Conflicts of Interest in Research" (2002) 347 N. Engl. J. Med. 579; B.M. Dickens, "Conflicts of Interests in Canadian Health Care Law" (1995) 21 American Journal of Law & Medicine, 259 [hereinafter *Dickens, Conflicts of Interests*].

[242] Conflicts of interest can also be created by the excessive remuneration of physicians by pharmaceutical companies, accepting fees for attending meetings and other promotional activities organized by pharmaceutical companies.

[243] See e.g, S. Puttagunta, T. Caulfield & G. Griener "*Conflict of Interest in Clinical Research: Direct Payment to Investigators for Finding Human Subjects and Health Information*" (2002) 10 Health Law Review, No 30-32, at 2; M. M. Chren, S. Landfeld, "Physicians' Behavior and Their Interactions with Drug Companies" (1994) 271JAMA 684.

A per-patient fee is paid to a researcher for conducting a clinical trial and normally is calculated based on the number of research subjects in a trial. The major concern with this type of financial incentives is their excessive amount, which doubles and triples the fees paid by provincial health plans for similar procedures.[244] The *TCPS* emphasizes that per-patient fees raise particular concerns when physicians have a therapeutic or other fiduciary relationship with the subjects, because they potentially can put a physician in a conflict between maximizing economic remuneration and serving the best interests of subject-patients. As a general guide, the *TCPS* suggests that per capita payments should be comparable to the physician's or researcher's usual professional fee.[245]

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[244] See M. Munro, "More than Healthy Returns: Doctors Have Found a Lucrative Sideline Enrolling Patients in Drug Trials for Pharmaceutical Companies", in *Drugs, Money & Ethics, supra,* note 238 February 24, 2004.

Finder's fees are fixed amounts of money paid to physician-researchers by commercial sponsors for enrolling eligible research subjects. These types of financial incentives have a significant potential to influence physicians' therapeutic decisions.[246] The principle concern with finders' fees, as put by Lemmens and Miller,

> [i]s that they may unduly influence the judgment of physicians as to the appropriateness of research participation for their patients. Finders' fees, in other words, give rise to a conflict between physicians' financial interests in patient recruitment, and their patients' interests in receiving their physicians' unbiased judgment as to what is in their best medical interests. When the researcher involves healthy subjects, the conflict is one between physicians' personal financial interests and their obligation to protect the prospective subjects from harm.[247]

Thus, acceptance by physician-researchers of finder's fees may result in the recruitment of ineligible (or marginally eligible) research subjects, erosion of informed consent and undermining of the clinical trials' scientific integrity. Lemmens and Miller maintain in this regard that,

> [e]very time a physician accepts finder's fee, he compromises his therapeutic obligation and violates his fiduciary obligation to act in the best interests of his patients,[248]

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[245] *TCPS*, *supra*, note 19 Article 7.3.

[246] E.M. Maher, "An Analysis of Finder's Fees in Clinical Research" (1994) 150 CMAJ 252.

[247] *Lemmens & Miller, supra*, note 18 at 401.

[248] *Ibid.* 402.

and further,

> The lure of finder's fees threatens more than physicians' fidelity to therapeutic obligations, patient access to care, and the consent process. It stands also to threaten the integrity of the scientific process, and to undermine public trust in science as a cooperative pursuit of basic social goods.[249]

The law recognizes that fiduciary obligations impose limits on the autonomy and freedom of those in a trusteeship position and therefore, in fiduciary relationships conflict-of-interest rules are notably severe. Citing the Supreme Court in *Hodgkinson*, Dickens argues that people who are in such positions "are required to act conscientiously to avoid conflict between any of their own interests and those of the dependent party they assume or otherwise come to under an obligation to protect" and that courts will hold them "to higher duties of protection of dependent parties' interests."[250] To that end, fiduciary law prohibits fiduciaries from placing themselves in a conflict of interest, as well as accepting remuneration for performing fiduciary duties.

The application of fiduciary principles in the context of commercially sponsored clinical trials suggests that physicians breach their fiduciary obligation when they accept payments or, for this purpose, any other remuneration in a course of conducting clinical research on patients that is beyond and above the reasonable compensation for the delivered services. This means that while it is not improper for physicians to be recognized and remunerated for doing research, the form and amount of remuneration should not serve as an incentive to ignore patient needs. Notwithstanding the fact that financial incentives such as finders' and per patient fees seem to have become a common practice in clinical trials, their legitimacy and permissibility should not be presumed. In fact, "[p]rohibitions against undue financial inducements to, for example, recruit patients as research subjects, is both possible and morally required".[251]

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[249] *Ibid.* 403.

A number of further observations about the management of conflict of interest is in order. There are a number of ways to manage conflicts of interests. The *TCPS*, for example, proposes a "proportionate" approach: If the conflict is insignificant, its disclosure to the research subjects and REB should be sufficient; however, a significant conflict of interests may warrant the researcher abandoning one of the conflicting interests. This means that the researcher may have to withdraw from the trial or give up care of the patient-subjects in a trial.[252]

It has been widely advocated that, at minimum, the law should compel physicians to disclose to patients the existence of incentives that may cause them to consider factors other than the patient's best interests.[253] However, the

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[250] *Dickens, Conflict of Interest, supra,* note 241at 262.

[251] K. C. Glass & T. Lemmens, "Conflict of Interest and Commercialization of Biomedical Research: What is the Role of Research Ethics Review?" in T. A. Caulfield & B. Williams Jones, ed., *The Commercialization of Genetic Research: Ethical, Legal and Policy Issues,* (New York: Kluwer Academic/Plenum Publishers, 1999) at 84; T. Caulfield & G. Griener, "Conflicts of Interest in Clinical Research: Addressing the Issue of Physicians' Remuneration" (2002) 30 J L Med & Ethics 305.

[252] See *TCPS, supra*, note 4 at 4.1- 4.2. Some commentators expressed a concern about the application of the "proportionate approach" proposed in the TCPS, fearing that its broad interpretation may lead in some cases to justification of limiting disclosure to subjects, see *Cote,* supra, note 227, para 42 (QL)

[253] See T. Caulfield & G. Robertson, "Cost Containment Mechanisms in Health Care: a Review of Private Law Issues", (1999) 27 Man. L. J para 27 (online: QL). See also D.S. Shimm, *et al,*

simple fact of disclosure may not be sufficient in many cases to remove concerns about the independence of the physician-researcher's judgment.[254] Some subjects may not be sensitive to or unable to see the link between the physician's conflict and potential harm to themselves. Besides, as Fleetwood observed, "even if a conflict of interest is disclosed to the patient... it would be tough for the patient to know what to do with, or how to respond to, the information."[255] Moreover, after disclosing the conflict, a physician's judgment or actions may continue to be impaired by the secondary interest. In fact, disclosure may be made in such a way as to diminish the significance of the conflict, which would mostly serve to protect the interests of the "maker" and not the recipient of the disclosure.[256] In some cases, curing the conflict of interest with disclosure may also create a perception that it is acceptable for physician-researchers to act in conflict. Instead, physicians should be mindful that, while in a conflict of interest, they risk losing their patients-subjects' trust.[257]

"Conflicts of Interest in Clinical Practice and Research (New York: Oxford University Press, 1996) 321 at 325, whereas the author states that sources and mechanisms of funding, as well as stockholding ought to be disclosed.

[254] T.R. Cech & J.S. Leonard, "Conflicts of Interest: Moving Beyond Disclosure" (2001) 291 Science 989 at 989. See also R. Horton, "Conflicts of Interest in Clinical Research: Opprobrium or Obsession?" (1997) 349 The Lancet 1112.

[255] J. Fleetwood, "Conflicts of interest in Clinical Research: Advocating for Patient-Subjects" (2001) 8 Widener Law Symposium Journal, 105, at 109 as cited by *Lemmens & Miller supra*, note 18 at 411. See also *Dickens, Conflict of Interest, supra*, note 141 at 266-67, where he observes that "[t]he implication that prior disclosure resolves a conflict of interest is consistent with a number of respected approaches to the issue, but may fail to appreciate how few real options a patient has when disclosure is made". See also *Rodwin, Strains, supra,* note 12 at 246, where he observed that "[p]atients are usually in a poor position to monitor physicians, second-guess their judgment, or to discover and sanction breaches of trust".

[256] See especially M. A. Rodwin, "Physician's Conflict of Interest – The Limitations of Disclosure" (1989) 321 (20) NEJM 1405 at 1406.

[257] See *Lemmens & Singer, supra*, note 239 at 961.

The fiduciary obligation of physician-researchers may extend beyond the duty of disclosure. The fiduciary law requirement that physicians scrupulously avoid placing themselves in potential conflicts of interest arguably means that it is wrong for physician-researchers to enter any arrangements that may lead to conflicts of interest, no matter whether those conflicts will ever materialize.[258] The purpose underlying this strict requirement is to preserve the trust essential for the existence and proper functioning of socially valuable institutions such as a doctor-patient relationship. That is why even the appearance of a conflict of interest in the dealings of physicians and other practitioners delivering health services[259] is consistently discouraged.[260]

b) "Gag" Clauses

As previously mentioned, various factors in the organization and conduct of clinical trials can affect physician-researchers' ability to protect the interests of their patients in clinical research. The most obvious and powerful among them are physician-researchers' contractual obligations to commercial sponsors of research projects.

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[258] See *Dickens, Conflict of Interest*, note 241 at 262-64.

[259] See *Cox v. College of Optometrists of Ontario*, (1988), 65 O.R. (2d) 461 (Ont. Div. Ct.), a case where the court held that under the regulations of the Health Disciplines Act, health service providers must avoid an appearance of conflict of interest, when there is no real or potential conflict in the classic sense.

[260] See e.g., *TCPS, supra* note 4 at [4.1] that suggests that "[t]he appearance of a conflict may in some cases be as damaging as a real conflict".

Illustrative of the serious effect that the contractual arrangements can have on the interests of research subjects and clinical researchers is the well-known case of Nancy Olivieri, a medical researcher at the Hospital for Sick Children in Toronto. The pharmaceutical company sponsoring Dr. Olivieri's research threatened to sue her for breach of contract if she informed patients of what she believed was a potentially life-threatening effect of the drug being administered to them as part of a clinical trial. Although this case is often described in terms of the tension between researchers' freedom to conduct scientific inquiry and the right of pharmaceutical companies to protect their intellectual property,[261] the case also highlights other problems that are of great concern for fiduciary law. The main of them involves contractually imposed fetters on researchers' ability to freely and openly communicate with their patient-subjects about the treatment they are undergoing, particularly in relation to risks they run and the possibility of adverse effects. From the fiduciary law perspective, this type of contractual arrangements invariably attempt (1) to prevent physicians from fulfilling their obligation to disclose information material to subjects' decision to participate in research, and (2) to control the exercise by physicians of their professional discretion, thereby preventing them from adequately protecting the health and safety of research subjects.[262] Litman and Sheremeta, in their analysis of the Dr. Olivieri's conduct, came to the conclusion that she breached her fiduciary obligation to the research subjects by entering into a contract that prevented her from disclosing material information, and further explained that,

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[261] See *e.g.*, M. A. Somerville, "A Postmodern Moral Tale: the Ethics of Research Relationships" (2002) 1 Nature 316 online: www.nature.com/reviews/drugdisc

[262] The evidence that pharmaceutical industry attempts to influence the decisions doctors make in multitude of ways is documented and described in numerous studies and publications. See, e.g., *Komesaroff, supra,* note 240

> [f]iduciaries have no right to fetter, let alone put beyond their control, the discharge of their fundamental fiduciary responsibilities. ... the mere act of entering into an non-disclosure agreement with a sponsor company ... is a breach of fiduciary duty.[263]

There is a growing recognition that physicians have obligations to parties other than their patients. How should these obligations be reconciled? Fiduciary law suggests that physicians' prime responsibility is to their patients in all issues that involve patients' care. This means that when entering into relationships with other parties, physicians should hold themselves out as fiduciaries and patient advocates, so that their relationships with other parties can be built on this premise. Fiduciary law also strongly calls for a duty of disclosure. Consistent with that, Canadian case-law and ethical guidelines unequivocally state that physicians should disclose material risks to their patients. A failure to disclose a material risk motivated by personal interest, such as a desire to have a clinical trial continue or to avoid potential liability is a breach of fiduciary duty.[264]

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[263] See *Litman & Sheremeta, supra*, note 234 at 7.
[264] *Ibid.*

D. Summary

There is a sufficient basis in law to conclude that physicians involved in clinical research owe research subjects, especially those who are ill, a fiduciary obligation. This means that physician-researchers must put the good of patient-subjects before their research interests.

The fact that physicians in clinical trials combine patient care with research does not change the doctor-patient nature of their relationship with patient-subjects and does not lessen the obligation they owe them, but rather heightens and intensifies it. The undeniable presence of power imbalance in the relationships of physician-researchers and patient-subjects, considerable discretion exercised by the former, vulnerability trust of the latter provide a convincing evidence of the fiduciary nature of this relationship.

While it is natural and unavoidable for physicians who combine clinical practice with research to assume responsibilities towards the research project and third parties involved in it, these responsibilities must not deflect attention from their prime responsibility namely, the health and well being of patients in their care. Thus, for instance, limitations on open communications, like those in gag clauses with commercial sponsors, or incentives which put physicians in a conflict between their personal interests and the essential interest of research subjects, like finder's fees, must absolutely be prohibited. Physicians owe their patients the benefit of their independent advice and patients should not be denied this essential benefit when receiving treatment in the course of a clinical trial.

Although disclosure of conflicts of interest may be an effective measure for dealing with certain low-intensity conflicts, it is insufficient to remove concerns about the independence of physicians' judgment and their ability to meet their fiduciary obligation to patient-subjects in cases of pervasive conflicts of interest. In the latter case, physicians may have to choose between their role as prime care-givers and clinical researchers. Dissociating these two roles helps to ensure more adequate protection of the patients participating in clinical trials, to preserve the trust in the physician-patient relationship and to maintain the integrity of both medical care and clinical research.

CONCLUSION

The analysis and discussion in this paper suggest that fiduciary law, the ultimate goal of which is to preserve and protect the integrity of socially valuable and necessary relationships arising from human interdependency, has an important role to play in regulating physician-patient relationships in clinical trials. By heightening and intensifying physician-researchers' obligations to patients and research subjects, it serves as an assurance of their protection in clinical research and a guarantee of the continuing public trust in health care and research enterprise.

BIBLIOGRAPHY

Cases

Arndt v. Smith, [1997] 2 S.C.R. 539

Betesh v. United States, 400 F. Spp.238 (D.C.D.C. 1974)

Breen v. Williams, (1996) 186 C.L.R. 71 (H.C. Aust.)

B.(K.L.) v. British Columbia, [1998] 10 W.W.R. 348 (B.C.S.C.)

Cadbury Schweppes Inc. v. FBI Foods Ltd., [1999] 1 S.C.R. 142

Canadian Aero Service Ltd. v. O'Malley [1974] S.C.R.592

Canson Enterprises Ltd. v. Bougton & Co. (1991), 85 D.L.R. (4th) 129 (S.C.C.)

C.(C.D.) v. Starzecki (1995, [1996]) 2 W.W.R. 317 (Man Q.B.)

Chase Manhattan Bank N.A. v. Israel-British Bank (London) Ltd., [1981] Ch. 105

City of Toronto v. Bowes, (1854), 4 Gr.49

Cobbs v. Grant, (1972) 8 Cal. 3d 229, 242 [104 Cal. Rptr. 505, 502 P. 2d 1.

Cox v. College of Optometrists of Ontario, (1988), 65 O.R. (2d) 461 (Ont. Div. Ct.)

Frame v. Smith (1888), 42 D.L.R. (4th) 81 (S.C.C.)

Gerula v. Flores (1995), 126 D.L.R. (4th) 506 (Ont. C.A.)

Giradet v. Crease and Co. (1987), 11 B.C.L.R. (2d) 361 (S.C.)

Goodbody v. Bank of Montreal (1974), 47 D.L.R. (3d) 335, (Ont. H.C.)

Guerin v. The Queen, [1984], 2 S.C.R.335

Halushka v. University of Saskatchewan [1966] 53 D.L.R. (2d) 436 (C.A.)

Henderson v. Johnston [1956], O.R. 789

Hodgkinson v. Simms [1994] 3S.C.R.377

Hopp v.Lepp (1980), 2 S.C.R. 192

Keech v. Sandford (1726), 25 E.R. 223 (Ch.)

Kenny v. Lockwood, [1932] O.R.141

Lac Minerals Ltd. v. International Corona Resources Ltd., [1989] 2 S.C.R. 574

Law Estate v. Simice, (1994), 21 C.C.L.T. (2d) 228 (B.C.S.C.), aff'd [1996] 4 W.W.R. 672 (C.A.)

Lloyd's Bank v. Bundy, [1975] 1 Q.B. 326 (C.A.)

McInerney v. McDonald, [1992] 2 S.C.R. 138

M(D.M.) v. Pilo, [1996] O.J. No. 938 (QL) (Gen. Div.)

Moore v. Regents of the University of California, 793 P. 2d 479 (Cal. 1990), cert. denied, 111 S. Ct. 1388 (1991)

Mussani v. College of Physicians and Surgeons of Ontario [2003] O.J. No 1956

Norberg v. Wynrib, [1992] 2 S.C.R. 227

N.Z. Netherland Society 'Oranje' Inc. v. Kuys, [1973] 2 All E.R. 1222

R. v. Dersch, [1993] 3 S.C.R. 768

R. v. Osolin (1993), 109 D.L.R. (4th) 487 (S.C.C.)

R. v. O'Connor (1995), 130 D.L.R. (4th) 235 (S.C.C.)

Parslow v. Masters, [1993] 6 W.W.R. 273

Pegram v. Herdrich, 530 U.S. 211 (2000)

Pittman Estate v. Bain (1994), 112 D.L.R.(4d) 257 (Ont. Gen. Div.)

Reibl v. Hughes, (1980) 2 S.C.R. 880

Rowe v. Grand Trunk Railway Co. (1866), 16 U.C.C.P. 500

Schloendorff v. New York Hospital, 105 N.E. (N.Y. C.A. 1914) 92

Sidaway v. Bethlem Royal Hospital Governors [1985] A.C. 871 (H.L.)

Tarasoff v Regents of the University of California. 551 P.2d 334 (Sup. Ct. Cal. 1976).

Vasdani v. Sehmi, [1993] O.J. No. 44 (QL) (Gen Div.)

Weiss v. Solomon, 48 C.C.L.T. 280

Acts of Parliament, Codes of Ethics, Guidelines, Policy Documents and Reports

American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics, E-2.07 Clinical Investigation online: <http://www.ama.assn.org/ama/pub/category.4301.html>

The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979) online: <http://www.nihtraining.com/ohsrsite/guidelines/belmont.html>

"Building on Values: The Future of Health Care in Canada" (2002) *Report of the Commission on the Future of Health Care in Canada*, at 83 online: <http://dsp-psd.communication.gc.ca/Collection/CP32-85-2002E.pdf>

Civil Code of Quebec, S.Q. 1991, c.64.

Draft-Report of the National Placebo Working Committee, November 2003, Section 4 B online: <http://www.cihr-irsc.gc.ca/e/services/19301.shtml>

Final Report of the Advisory Committee on Human Radiation Experiments (Washington, D.C.: U.S. Government Printing Office, 1995)

Food and Drug Act, SRC c.F-27 and *Food and Drug Regulations*, CRC, c.870, Part C, Division 5, 8

International Ethical Guidelines for Biomedical Research Involving Human Subjects, CIOMS, Geneva, 2002 at 7 online: <http://www.cioms.ch/frame_guidelines_nov_2002.htm>

Nuremberg Code, from "Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10", Vol. 2, Nuremberg, October 1946 - April 1949. (Washington, DC: US Government Printing Office, 1949). 181 online: <http://ohsr.od.nih.gov/nuremberg.php3>

Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans, Public Works and Government Services Canada, 1998, online: <http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm>

World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects, (1964), as last amended in 2002 online: <http://www.wma.net/e/policy/b3.htm>

World Medical Association International Code of Medical Ethics, as last amended in October 1983 online: <http://www.wma.net/e/pollicy/c8.htm>

Publications

W.W. Arkinstall, "Interaction Between Physicians and the Pharmaceutical Industry [letter] (1995) 153:4 CMAJ 398

T. M. Banks, "Misusing Informed Consent: A critique of limitations on research subjects' access to genetic research results" (2000) 63 Sask. L. Rev. 539 H. K. Beecher, Research and the Individual: Human Studies (Boston: Little, Brown and Company, 1970)

H.K. Beecher, "Ethics and Clinical Research" (1966) 274 N Engl J Med 1354

J.E Bekelman, et al. "Scope and Impact of Financial Conflicts of Interest in Biomedical Research. A Systematic Review", (2003) 289:4 JAMA 454

T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics,* 2nd ed., (Oxford University Press, 1983)

D. Blumenthal, et al., "Relationships Between Academic Institutions and Industry in the Life Sciences – An Industry Survey" (1996) 334: 6 N Engl. J Med 368

T. Bodenheimer, "Uneasy Alliance – Clinical Investigators and the Pharmaceutical Industry" (2000) 342:20 N. Engl. J. Med.1539

P.C. Borzi, "Pegram v. Herdrich: A Victory for HMOs or the Beginning of the End for ERISA Preemption?" (2001) Yale J. Health P'y L & Ethics 161

G. H. "Human Experimentation: History" in W. T. Reich, ed., *Encyclopedia of Bioethics* (New York, Free Press, 1978)

E.G. Campbell, K.S. Louis, D. Blumenthal, "Looking a Gift Horse in the Mouth: Corporate Gifts Supporting Life Sciences Research" (1998) 279:13 JAMA 995.

A.Campbell, K. C Glass, “The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research” (2001) 46:2 McGill Law Journal, 473

CanWest Series ”Drug, Money & Ethics” National Post, February 23-28, 2004

T. Caulfield & G. Griener, “Conflicts of Interest in Clinical Research: Addressing the Issue of Physicians’ Remuneration” (2002) 30 J L Med & Ethics 305.

T. Caulfield & G. Robertson, “Cost-containment Mechanisms in Health Care: A Review of Private Law Issues” (2000) 27 Man. L. J. 1

CBC, “Ideas”, “Manufacturing Patients” September 2003

T.R. Cech & J.S. Leonard, "Conflicts of Interest: Moving Beyond Disclosure" (2001) 291 Science 989

M. M. Chren & S. Landfeld, “Physicians’ Behavior and Their Interactions with Drug Companies” (1994) 271 JAMA 684

A.Côté, “Adequate Protection for the Autonomous Research Subject? The Disclosure of Sources of Funding and Commercialisation in Genetic Research Trials” (2002) 28 Man. L.J. 347 [online: QL]

J. Cowie, “Difference, Dominance, Dilemma: A Critical Analysis of Norberg v. Wynrib” (1994) 58 Sask. L. Rev. 357

R.A. Davidson, “Source of Funding and Outcome of Clinical Trials” (1986) 1 J Gen Intern Med 155

B. Dickens, ”Medical Records – Patient’s Right to Receive Copies – Physician’s Duty of Disclosure: McInerney v. MacDonald “, (1994) 73 Can. Bar. Rev. 234

B.M. Dickens ”Informed Consent” in T. Caulfield, J. Downie & C. Flood (eds), *Canadian Health Law and Policy,* (2ed) (Butterworths, Toronto, 2002)

B. Dickens, “Legal Issues: Governance Relations in Biomedical Research” in *The Governance of Health Research Involving Human Subjects* (HRIHS), Law Commission of Canada, 2000 at 93

B. Dickens, “Conflict of interest: Canadian Health Care Law” (1995) 21 Am J Law Med 259

M. V. Ellis, Professional Fiduciary Duties (Scarborough: Carswell, 1995)

M. V. Ellis, Fiduciary Duties in Canada, (Don Mills, Ontario: DeBoo, 1988)

E. Emmanuel & F. Miller, "The Ethics of Placebo-Controlled Trials: A Middle Ground" (2001) 345 N Engl J Med 915

P. D. Finn, *Fiduciary Obligations* (Sydney: The Law Book Company Limited, 1977)

P. D. Finn, "The Fiduciary Principle" in T.G. Youdan, ed., *Equity, Fiduciaries and Trusts* (Toronto: Carswell, 1989)

J. Fleetwood, "Conflicts of interest in Clinical Research: Advocating for Patient-Subjects" (2001) 8 Widener Law Symposium Journal, 105

N. Fontigny, "When Yes Really Means Yes: The Law of Informed Consent in Canada is Revisited" (1995) 4:3 Health L. Rev. 17

M. S. Frankel, The Public Health Service Guidelines Governing Research Involving Human Subjects, George Washington University Program of Public Studies in Science and Technology Monograph no. 10 (Washington, D.C.: 1972)

T. Frankel, "Fiduciary Law" (1983), 71 Cal. L. Rev. 795

B. Freedman, "Compassionate Access to Experimental Drugs and Catastrophic Rights", text of the presentation to the House of Commons Subcommittee on HIV/AIDS, Ottawa 13 December 1995, 3:1Canadian HIV/AIDS Policy & Law Newsletter, 1996

B. Freedman & K. C. Glass, "Weiss v. Solomon: A Case Study in Institutional Responsibility for Clinical Research" (1990) 18:4 Law, Medicine & Health Care 395

B. Freedman, "Equipoise and the Ethics of Clinical Research" (1987) 317 N. Engl. J.Med.141

B. Friedland "Physician-Patient Confidentiality", (1994) 15 J. Legal Med. 249

E.E. Gillese, *The Law of Trusts* (Ontario: Concord, 1997)

K.C. Glass & T. Lemmens, "Research Involving Humans" in J. Downie, T. Caulfield & C. Flood, *Canadian Health Law and Policy,* ed, (2nd ed) (Butterworths: 2002) 475

K. C. Glass & T. Lemmens, "Conflict of Interest and Commercialization of Biomedical Research: What is the Role of Research Ethics Review?" in T. A. Caulfield & B. Williams Jones, ed., *The Commercialization of Genetic Research: Ethical, Legal and Policy Issues*, (New York: Kluwer Academic/Plenum Publishers, 1999) 84

J.A. Goldner, "Dealing with Conflicts of Interest in Biomedical Research: IRB Oversight as the Next Best Solution to the Abolitionist Approach" (2000) 28 J.L. Med. & Ethics 379

R. Gordon, *The Alarming History of Medicine*, (Mandarin Paperback, 1993)

G. Guyatt, "Academic Medicine and the Pharmaceutical Industry: a Cautionary Tale" (1994) 150:6 CMAJ 951

Henrik Bendixen to Henry Beecher, March 1966, *Henry Beecher Manuscripts*, Francis A. Countway Library of Medicine, Harvard University

A. B. Hill, "Medical Ethics and Controlled Trials" (1963) 1 Brit. Med. J. 1043

A.R. Holder, "Do Researchers and Subjects Have a Fiduciary Relationship?" (1982) IRB 6

R. Horton, "Conflicts of Interest in Clinical Research: Opprobrium or Obsession?" (1997) 349 The Lancet 1112

M.L. Howard, "Physician-Patient Relationship" in Legal Medicine, 4th ed., (American College of Legal Medicine, 1988) 247

I. Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health* (Harmondsworth, Penguin Books, 1977)

J.C. Irvine, "The Physician's Duty in the Age of Cost-containment", in *Current Issues in Health Law,* The 1994 Isaac Pitblado Lectures, Sponsored by The Law Society of Manitoba, The Manitoba Bar Association and the University of Manitoba, Faculty of Law, 128

N.S. Jecker, "Divided Loyalties: Caring for Individuals and Populations", (2001) Yale J. Health P'y L & Ethics, 177.

N.E. Kass, et al., "Trust: The Fragile Foundation of Contemporary Biomedical Research," (1996) 26:5 Hastings Center Report 25

J. P. Kassirer & M. Angell "Financial Conflicts of Interest in Biomedical Research" (1993) 329 N Engl J Med 570

J. Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984)

I. Kennedy, *Treat me Right: Essays in Medical Law & Ethics* (Clarendon Press, Oxford: 1988)

A.Klass, *There is Gold in Them Thar Pills* (Narmondsworth: Penguin Books, 1975)

B.M. Knoppers, "Ethics and Human Research: Complexity or Confusion?" in The Governance of Health Research Involving Human Subjects (HRIHS), Law Commission of Canada, 2000

P. Komesaroff, "Doctors' Interactions with the Pharmaceutical Industry: Science or Commerce?" (Editorial) (2001) 31 Intern Med J 446

P. Kosseim, "The Landscape of Rules Governing Access to Personal Information for Health Research: A View from Afar" (2003) Health L. J. Special Edition "Health Law in the 21st Century" 113

R. P. Kouri, "The Law Governing Human Experimentation in Quebec" (1991), 22 R.D.U.S. 77.

Krever, J & Lewis, "Fiduciary Obligations and the Professions" in *Special Lectures of the Law Society of Upper Canada: Fiduciary Duties 1990* (DeBoo: 1991)

T. Lemmens & P.B. Miller, "The Human Subjects Trade: Ethical and Legal Issues Surrounding Recruitment Incentives" (2003) 31 J. L. Med. & Ethics 398

T. Lemmens & P. Singer, "Bioethics for Clinicians: 17. Conflict of Interest in Research, Education and Patient Care" (1999) 159 JAMC 960,

R. Levin, "The Boundaries Between Biomedical or Behavioral Research and the Accepted and Routine Practice of Medicine" in *The National Commission for the Protection for Human Subjects of Biomedical and Behavioral Research and Food and Drug Administration Rules and Regulations.* Fed. Reg, Vol. 46, No17, 1981: 56: 102 (c).

N. Levinsky, "Nonfinancial Conflicts of Interest in Research" (2002) 347 N. Engl.J. Med. 579

J. Lexchin, "Interactions Between Physicians and the Pharmaceutical Industry: What Does the Literature Say?" (1993) 149:10 CMAJ 1401

S. Lewis et al., "Dancing with the Porcupine: Rules for Governing the University-Industry relationship," (2001) 165:6 CMAJ 783

C.W. Lidz et al., "Therapeutic Misconception and the Appreciation of Risks in Clinical Trials" (2004) 58:9 Social Science & Medicine 1689

R.J. Lilford, "Ethics of Clinical Trials from a Bayesian and Decision Analytic Perspective: whose Equipoise it is Anyway?" (2003) 326 BMJ 980

M. Litman & L. Sheremeta, "The Report of the Committee of Inquiry on the Case Involving Dr. Nancy Olivieri: A Fiduciary Law Perspective" (2002) 10:2 Health L. Rev. 3.

A. Mackinnon, "How Important is Consent for Controlled Clinical Trials?" (1996) 5:2 Cambridge Quarterly of Healthcare Ethics 221

P.D. Maddaugh, "Definition of Fiduciary Duty" in *Special Lectures of the Law Society of Upper Canada 1990*, (DeBoo: 1991) 15

E.M. Maher, "An Analysis of Finder's Fees in Clinical Research" (1994) 150 CMAJ 252.

M. A. Marshall, "Civil Action for Damages for Sexual Abuse by Physicians" (1993) 1 Health L J 85

J. Mason, R. McCall Smith, *Law and Medical Ethics*, 4th ed, (Butterworths, 1994)

A.Mason, 'Themes and Prospects', in P. D. Finn, ed., *Essays in Equity* (Sydney: Law Book Co., 1985)

J.D. McCamus, "The Recent Expansion of Fiduciary Obligation: Common Themes and Future Developments" 23 E.T.R. 301

"Prometheus Unborn: Fiduciary Obligation in the Supreme Court of Canada" (1997) 28 Can Business L J 107

D.Mechanic, "The Functions and Limitations of Trust in the Provision of Medical Care" (1998) 23:4 J. Health Politics, Policy & Law 661

F.G. Miller & H. Brody, "What Makes Placebo-Controlled Trial Unethical?" (2002) 2:2 Am. J. Bioethics 3

R. Nowak, "Problems in Clinical Trials Go Far Beyond Misconduct" (1994) 264 Science 1539

E.D. Pellegrino, "Trust and Distrust in Professional Ethics," in *Ethics, Trust and Professions: Philosophical and Cultural Aspects,* ed. E.D. Pellegrino, R.M. Veatch & J.P. Langan (Washington D.C.: Georgetown University Press, 1991) 69

E.D. Pelegrino & D.C. Thomasma, *A Philosophical Basis of Medical Practice*, O.U.P., 1981

S. Piantadosi, *Clinical Trials: A Methodologic Perspective* (Paperback, John Wiley & Sons, 1997)

E.I. Picard & G.B. Roberson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996)

D.Pulman, "Subject Comprehension, Standards of Information Disclosure and Potential Liability in Research" (2001) 9 Health L. J.

S. Puttagunta, T. Caulfield & G. Griener "Conflict of Interest in Clinical Research: Direct Payment to Investigators for Finding Human Subjects and Health Information" (2002) 10 Health Law Review, No 30-32

S. J. Reiser & M. Anbar, ed., *The Machine at the Bedside: Strategies for Using Technology in Patient Care* (New York: Cambridge University Press, 1984)

The Right Honourable Sir Robert Megarry, "Historical Development" in *Special Lectures of the Law Society of Upper Canada: Fiduciary Duties 1990* (DeBoo: 1991)

G. B. Robertson "Informed Consent 20 Years Later" in Health L J 2003 Special Edition, 153

M. A. Rodwin, "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System" (1995) 21 Am. J. L. & Med. 241

M. Rodwin, *Medicine, Money, and Morals: Physicians' Conflict of Interest* (New York: Oxford University Press, 1993)

M. A. Rodwin, "Physician's Conflict of Interest – The Limitations of Disclosure" (1989) 321:20 NEJM 1405

D.J. Rothman, *Strangers at the Bedside: History of How Law and Bioethics Transformed Medical Decision Making* (Basic Books: 1991)

L.I. Rotman, "Fiduciary Doctrine: A Concept in Need of Understanding" (1996) 34:4 Alta. L. Rev. 821

D.J. Roy, J.R. Williams & B.M. Dickens, *Bioethics in Canada* (Toronto: Prentice Hall Canada Inc., 1993)

D.L Sackett, "Bias in Analytic Research." 32 Journal of Chronic Disease (1979) 51

A.W. Scott, "The Fiduciary Principle" (1949) 37 Cal. L. Rev. 541

A. Silversides, "Private Sector Becoming the Key to Research Funding In Canada" (1998) 159 CMAJ 397.

B. Simmons, "Problems in Deceptive Medical Procedures: An Ethical and Legal Analysis of the Administration of Placebos" (1978) 4 J Med Ethics 172

J. C. Shepherd, *The Law of Fiduciaries* (Toronto: Carswell, 1981)

S. Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992)

D.S. Shimm et al, *Conflicts of Interest in Clinical Practice and Research* (New York: Oxford University Press, 1996)

R.G. Slaght, "Proving a Breach of Fiduciary Duty" in *Special Lectures of the Law Society of Upper Canada: Fiduciary Duties 1990* (DeBoo: 1991)

M. A. Somerville, "A Postmodern Moral Tale: the Ethics of Research Relationships" (2002) 1 Nature 316 online: www.nature.com/reviews/drugdisc

M. Stauch & K. Wheat with J. Tingle, *Sourcebook on Medical Law* (Cavendish Publishing Ltd, 1998)

R. M. Veatch, *The Patient-Physician Relation: The Patient as Partner, Part 2*, (Indiana University Press, 1991).

D. Waters, *The Law of Trusts in Canada*, 2nd ed. (Toronto: Carswell, 1984)

C. Weijer et. al., "For and Against: Clinical Equipoise and not the Uncertainty Principle is the Moral Underpinning of the Randomized Controlled Trial" (2000) 321 BMJ 756 online: <http://bmj..bmjjournals.com/cgi/eletters/321/7263/756>

C.Weijer, The Analysis of Risks and Potential Benefits in Research" (1999) NCEHR 9:2 & 10:1 Communique

Weijer, "Demarcating Research and Treatment: A systematic Approach for the Analysis of the Ethics of Clinical Research (1992) 40 Clinical Research 653

E. J. Weinrib, "The Fiduciary Obligation" (1975) 25 U. Toronto L. J. 1

S.M. Wolfe, "Why do American Drug Companies Spend More Than $ 12 Billion a Year Pushing Drugs? Is it Education or Promotion?" (1996) 11 J Gen Intern Med 637

R. Worton & R. Saginur, "Worth the Risk", *Ottawa Citizen*, March 9, 2004, A15.

J.A. Zivin, "Understanding Clinical Trials" (2000) 4 Scientific American 69